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Carcinoma of the Stomach*

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CANCER of the stomach poses problems of the greatest importance to all of us because of its high incidence, its rapidly fatal course unless treated in its early stages, and, especially, the general air of pessimism which surrounds the whole subject. It is the spectre at the banquet of our surgical complacency. I have elsewhere stated that doctors might well be divided into two classes: those who are forever suspicious of gastric cancer and never find it and those who are never suspicious of it and forever miss it. The former may be comforted by the fact that they have committed no sin of omission. The latter must bear that odium. It must be a distressing experience to have the diagnosis finally become obvious in a patient who has been treated symptomatically for a long period without having had a careful, searching study made to rule out this serious disease. However, this often occurs, not only adding to the problem that the surgeon is ultimately called upon to answer, but giving rise to unjust criticism of the surgical treatment, which after all is the only known method at present which offers any chance of cure.

That there are instances in which even the most careful search might fail to reveal the lesion is granted, but they are rare. In the great majority the diagnosis could be made much earlier if all of the means at our command were used with skill. The first physician to see the patient is so often the one on whom the fate of the patient rests, for if this physician—be he general practitioner, internist, gastro-enterologist or surgeon—fails to be suspicious of this disease and searching in its detection, we will continue to see late, inoperable, hopeless cases arrive and the pessimism will daily grow. A culpable attitude of pessimism is that which holds that the disease is hopeless from the beginning and, once the diagnosis is made, dismisses the problem with a warning to the patient to prepare to die. This attitude of mind will not admit that anyone was ever cured of gastric cancer by surgery, using the word "cure" in the same fashion that we use it in any other type of malignancy. This in spite of increasing evidence to the contrary. In 1941 The Registry of The American College of Surgeons had 1,249 instances of five-year cures recorded, and there must be many more that have not been mentioned.

That surgery is not the ideal answer is admitted, but not to use it is like refusing to rescue a drowning man because you have to pull him into a rowboat instead of being able to part the waves before him. All surgeons complain that the difficulties come from the extension of the process to regions outside the stomach. As a matter of fact, we usually have to treat the complications of the disease, including involvement of many other structures outside the primary site. If a cancer is treated while still confined to the stomach, the chance of long survival is great, and yet studies on autopsy material have shown that as high as 23 per cent of patients have died before any metastasis had occurred (Warwick). It is obvious that many might have been saved by early operation.

Why is the diagnosis not made earlier? Several reasons occur—the patient's indifference to mild symptoms, the careless or incomplete examination, and reliance upon one negative examination in the face of continuing symptoms. I am convinced that it is dangerous to consider gastric ulcer as anything other than a surgical lesion from the very beginning. The therapeutic test of such an ulcer may be greatly misleading unless it is interpreted with proper reservations. It is not generally understood that it is not possible to differentiate malignant from benign ulcer in a very high percentage of cases, nor is the great incidence of carcinoma appreciated. It remains a fact that the majority of

* Chairman's address, presented as part of a panel discussion on Carcinoma of the Stomach at the Seventy-fifth Annual Session of the California Medical Association, Los Angeles, May 7-10, 1946.

cases reach the surgeon months after the onset of symptoms and sometimes even after years. Many have been treated as benign ulcers or as some form of indigestion without having had the benefit of x-ray or gastroscopic investigation. Such fundamental studies as gastric analysis or a search for the causes of unexplained anemia or asthenia, or for the source of occult blood in the stool are left undone while the patient and the doctor are lulled by temporary, often empirical measures.

The extent of surgical ablation of the stomach and contiguous structures in the treatment of gastric cancer has been stretched to the limit and little more can be expected from technical refinement. It is therefore our duty to continue to press the need of recognizing the disease in its early stage and while it is still susceptible to the only means of cure that we now know—surgical removal. Too frequently, the surgeon, feeling that every patient in whom the diagnosis of cancer of the stomach is made is entitled to operation unless that course is obviously hopeless, is compelled to take heroic measures to overcome advanced disease. Too often he has to decide if he has anything to offer to make easier the final days in a battle that was lost before he entered the field. It is therefore our duty constantly to remind the one who first sees the patient to be eternally suspicious and thorough in his search for gastric cancer in all patients who have mild digestive symptoms.

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What Can the Internist Do to Get More Early Cases Of Carcinoma of the Stomach to the Surgeon?*

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A MALE patient, 52 years of age, entered the hospital with the complaint of vomiting for one month, abdominal pain for three months and a weight loss of 25 pounds during the previous six months.

He had been perfectly well until two years before entry into the hospital when he first began to notice some vague epigastric distress following meals and a distaste for certain foods, particularly meat. He noted mild relief of his symptoms for several months with various self-prescribed medications directed to relieve his "acid indigestion," but for a month before entry he had had a great deal of vomiting and abdominal pain. His weight had gradually declined from 175 pounds to 150 pounds.

Physical examination revealed a man showing signs of some recent weight loss. Nothing else of significance was noted until the abdomen was examined. An indefinite mass could be palpated in the epigastrium. The liver edge was easily felt beneath the right costal margin. The liver was slightly larger than usual and the edge felt hard and somewhat lumpy. Digital examination of the rectum revealed a hard, fixed, non-tender mass in the cul-de-sac which was typical of a rectal shelf. A large filling defect involving the lower half of his stomach was seen on x-ray examination, and there was also a moderate degree of pyloric obstruction with some retention of the barium meal. Achlorhydria and low total acid was present on gastric analysis and the fasting content contained occult blood. The diagnosis of carcinoma of the stomach at this stage was relatively obvious, and in the presence of metastases in the peritoneum and liver, the lesion was considered inoperable.

DELAY IN DIAGNOSIS

It is a sad commentary that about one-half of the patients with carcinoma of the stomach when admitted to hospitals in the United States are considered inoperable. Better therapeutic results and a change in the pessimistic viewpoint shared by most of us can hardly be expected while such a situation exists. However, the purpose of this discussion is not what must be done to educate patients so that they seek assistance early in the course of the disease, but rather to emphasize certain factors that will aid the doctor in early recognition of the lesion. The doctor many times is slow in making a diagnosis, and too often several months go by before the gravity of the situation is realized. The diagnosis of carcinoma of the stomach is not always easy and at times the combined efforts of the doctor, radiologist, gastroscopist and surgeon must wait for the last word to come from the pathologist as to whether the lesion is benign or malignant.

The onset of the disease is often abrupt. The symptoms of anorexia and gastric distress make their appearance in a patient who previously had been entirely free of gastro-intestinal symptoms. It is in this group of patients with symptoms that we can hope for earlier recognition of the lesion.

* Presented as part of a panel discussion on Carcinoma of the Stomach at the Seventy-fifth Annual Session of the California Medical Association, Los Angeles, May 7-10, 1946.

There is little to offer those patients in whom the first manifestations of the disease are the result of widespread metastases as is sometimes seen in lymphogenous pulmonary spread or in carcinomatosis of the peritoneum.

In some quarters there is a tendency to minimize the value of gastric analysis, perhaps too much. It is quite true that the presence of high or low acid values is not particularly helpful in distinguishing a benign from a malignant ulcer, but on occasions blood may be found in the fasting content when the lesion, because of size or position, is most difficult to demonstrate by x-ray. Further attention then directed to examination of the stomach by x-ray or gastroscopy may be revealing.

EXAMINATION OF STOOL

Examination of the stool for occult blood is a very simple test but one that is at times neglected. The presence of occult blood in the stool is an indication for investigation of the gastro-intestinal tract to determine the source of the bleeding. Malignant disease of the colon, small bowel or stomach may be latent, and occasionally the finding of occult blood in the stool will lead to its discovery. Once an ulcer is demonstrated in the stomach, the question resolves as to whether it is benign or malignant, and from the clinical standpoint there is no infallible rule to make the distinction, at least in the early stages when it is important to do so.

Various clinics throughout the country have more or less arbitrarily established the principle that a gastric ulcer should be observed from three to six weeks after adequate dietary and medical treatment has been instituted. Then if the ulcer remains and does not show appreciable regression in size, surgical intervention is indicated. However, one must not be lulled into a sense of security if the patient responds well to medical and dietary management. Remarkable improvement, with disappearance of symptoms, gain in weight and strength, a feeling of well-being, and an apparent healing of the gastric ulcer, may occur even if the lesion is a carcinoma.

Since numerous studies have shown that the pre-pyloric area is the location of most gastric carcinomas, one is justified in viewing a pre-pyloric ulcer with great suspicion. Most ulcers of the greater curvature of the stomach are malignant. In fact the finding of a benign ulcer on the greater curvature is so unusual that all ulcers in this location should be considered carcinomatous until proven otherwise.

It will be well to mention the natural course of this disease and to emphasize the fact that often it is extremely chronic and extends over a period of years. Instances where the duration has been 15 to 20 years have been reported and a duration of four to five years is not infrequent. I have in mind one patient who had a large carcinoma of the stomach which was considered inoperable, mainly because of size. Almost two years later the general condition of the patient had not deteriorated and the x-ray picture was identical to that on the first examination. He was then operated on and an extensive resection carried out because of the involvement of both the colon and small bowel by a large carcinoma of the stomach. He died more than three years later of extensive metasteses.

SIZE NOT INDICATIVE OF TENDENCY TO METASTASIZE

It would be well to emphasize that the size of the lesion in the stomach is not a true indication of its tendency to metastasize. Large tumors at times are very slow in their spread while the smallest of tumors may be the primary site from which there are extensive metastases. The size of a chronic gastric ulcer is no true indication of malignancy. However, generally speaking, there is greater chance that the large ulcers are malignant.

The increased incidence of carcinoma of the stomach in patients with pernicious anemia is definitely established. The association of these two diseases is generally recognized. There is likewise a greater incidence of gastric polyps in pernicious anemia. Especial attention should be directed to the stomach in pernicious anemia and patients with this disease should be examined from time to time by x-ray and/or gastroscopy. The increased life span of pernicious anemia patients brought about by liver therapy gives additional time for development of cancer or pre-cancerous lesions in the stomach of these patients. The underlying basic change in the stomach is a hyperplastic atrophic gastritis with metaplasia of the epithelium and a hyperplasia of the mucous glands.

It seems that what we must stress at the present time is, first of all, that carcinoma of the stomach be recognized early and that we should realize that there are many patients in whom the diagnosis could be made at a much earlier stage than is frequently the case. It has been my feeling for a long time that when the surgeon operated on a patient in whom a clinical diagnosis of carcinoma of the stomach could be made with a fair amount of certainty, the prognosis for that patient was definitely poorer than when the ulcer was considered benign, from the clinical standpoint. This has been borne out in recent reports by Allen and his group in which they showed a 20 per cent five-year cure in those patients with a preoperative diagnosis of carcinoma of the stomach and a 40 per cent five-year cure when the preoperative diagnosis was benign ulcer and the malignancy was determined later by microscopic examination.

With the steadily improving results and reduced mortality of gastric resection and the early recognition of carcinoma of the stomach, we can hope that in the future the outlook for this disease will be more encouraging.

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What Does Gastroscopy Offer in the Early Diagnosis of Cancer of the Stomach?*

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TO discuss generally the usefulness of gastroscopy in the diagnosis and management of gastric carcinoma would embrace too wide a field, indeed, for a panel discussion. The purpose of this paper is to discuss the value of gastroscopy for the early diagnosis of gastric carcinoma only.

Livingston's and Pack's admirable book on the end-results in the treatment of gastric carcinoma is the best and quite unique source of information about the huge problem as a whole. However, there are two little pessimistic sentences to which I think exception should be taken. They read: "For approximately 75 per cent of patients with the disease surgery offers not the faintest hope for cure. Gastric surgery does not, *nor is it likely in the future,* to prove a satisfactory answer for more than the smallest number of patients." It is to be hoped that this pessimistic attitude for the future will have to be modified.

Formerly, benign ulcer of the stomach was considered to be a precursor of cancer and resection for every benign ulcer of the stomach seemed justified at that time. This opinion recently has been reversed rather completely. In fact, clinical observation has taught us that benign ulcer of the stomach most rarely, if ever, will be transformed into cancer; and a majority of clinicians have become most reluctant in advising early surgery in a disease which so often yields most satisfactorily to internal treatment. Therefore, the necessity has arisen to come to an early and rapid differential diagnosis between the two diseases.

Whenever an ulcer crater of the lesser curvature can be demonstrated, the question immediately arises: Is this ulcer benign or malignant? Waiting is dangerous. The so-called therapeutic test, as will be shown later, is unreliable; precious time may be lost. X-ray—naturally the most important method for the diagnosis—often cannot make this differential diagnosis. The experienced radiologist knows that carcinomatous infiltration and inflammatory swelling around the benign ulcer often cannot be differentiated, and that on the other hand apparent lack of infiltration does not exclude carcinoma. Gastroscopically, however, this differential diagnosis often becomes possible at one glance. Table 1 shows the results of x-ray examination and gas-

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TABLE 1.—*X-ray and Gastroscopy—91 Cases of Gastric Carcinomas*

A.—Failures.				
X-ray indefinite Gastroscopy wrong 1				
X-ray wrong Gastroscopy indefinite 3				
Both wrong ..... 3 (3.3)%				
7 (7.7%)				
B.—Correct Diagnosis.				
			X-ray Correct	Gastroscopy Correct
Both methods correct.....56 (61.5%)			56	56
X-ray correct Gastroscopy indefinite	1			
X-ray correct Gastroscopy wrong	1			
Lesions seen by x-ray not seen by gastroscopy..	5			
7 (7.7%)	7		7	
Gastroscopy correct X-ray indefinite	12 (13.2%)			
Gastroscopy correct X-ray wrong	4			
Lesions seen by gastroscopy—not seen by x-ray..	5			
21 (23.1%)	21			21
			63 (69.2%)	77 (84.6%)
Correct diagnosis after use of both methods.....84 (92.3%)				

troscopy in 91 cases of gastric carcinoma. The correct diagnosis was missed, more or less, in seven cases by both methods. In 56 cases both methods were equally successful. X-ray was definitely superior in seven additional cases, and gastroscopy permitted a definite diagnosis in 21 additional cases. This surprising result is explained by the line, "gastroscopy correct, x-ray indefinite."

In no fewer than 12 cases, only an indefinite diagnosis could be made at x-ray examination, while the gastroscopic diagnosis was quite definite. All these cases concerned the differential diagnosis between benign and malignant ulcer.

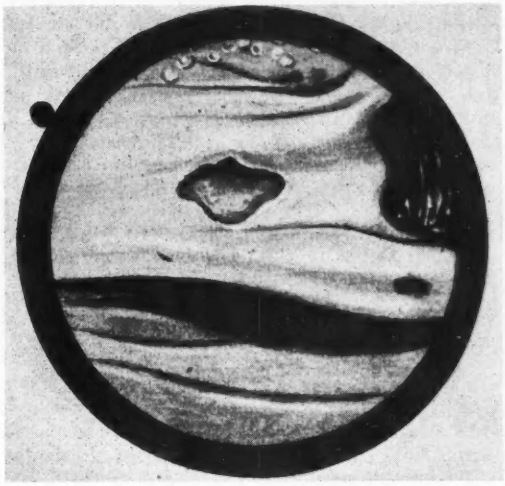

Figure 1.—*Gastroscopic picture of a benign ulcer of the lesser curvature.* At right (between 2 and 3 o'clock) cavity of the antrum is seen limited below by the musculus sphincter antri which contains a mucosal pigment spot. Ulcer is in middle of picture. It is characterized by its sharply cut-out margin. In the gastroscopic view the brilliant yellowish-white floor contrasts sharply with the surrounding orange-red mucosa.

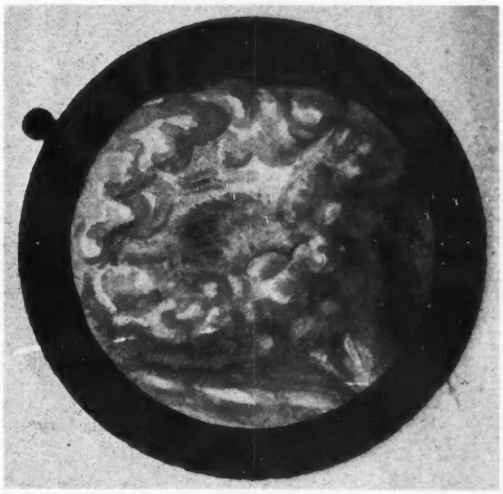

Figure 2.—*Gastroscopic picture of a malignant ulcer of the lesser curvature.* At right is the entrance to the antrum. The ulcer, in the middle of the picture, has no sharp demarcation and is surrounded by stiff nodules.

How is this possible? The surgeon and the pathologist know that in the inspection of the gross specimen they cannot make this differential diagnosis, and ten years ago they used to pat benevolently the back of the gastroscopist and admonish him to desist in his audacious attempts. They know now that at gastroscopy the blood is still circulating and that the color contrasts make the picture vivid and marked as it never can be seen in the gross specimen. Figure 1 shows the typical benign ulcer, its floor being yellowish or whitish, its margin sharply cut out. Figure 2 represents the gastroscopic view of a malignant ulcer. At x-ray examination it would look like the benign ulcer of Figure 1, but at gastroscopic examination the aspect is a totally different one: the edges of the malignant ulcer at gastroscopy are not sharply cut out but blend diffusely with the surrounding mucosa.

The reason for this difference is demonstrated by the microscopic sections of Figures 3 and 4. Figure 3 is a microscopic section through a benign ulcer; Figure 4 is a microscopic section through a malignant ulcer. In both cases the crater would appear alike at the inspection of the gross speci-

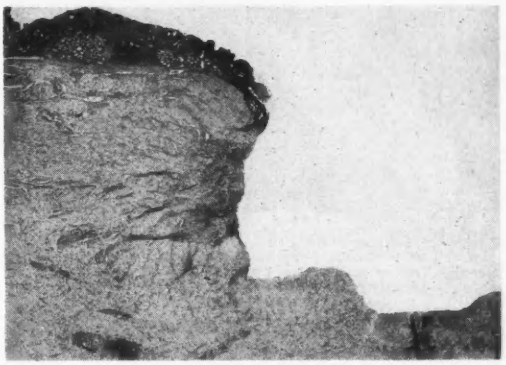

Figure 3.—*Microscopic section through the edge of a benign ulcer.* Ulcer crater, at right of picture is sharply demarcated toward the mucosa. This sharp demarcation can be seen at gastroscopic observation because of the marked color difference, but cannot be seen at the inspection of the bloodless gross specimen.

Figure 4.—*Microscopic section through a malignant ulcer.* The carcinomatous tissue of the ulcer crater extends across the edge of crater and undermines gradually the mucosa. This gradual imperceptible transition is readily seen at gastroscopic observation but cannot be observed in the inspection of the bloodless gross specimen.

men and at x-ray examination. However, in the benign ulcer the mucosa ends abruptly at the edge of the crater and this abrupt edge is seen as a sharply cut out margin at gastroscopy. In the malignant ulcer the tumor tissue creeps over the edge of the crater and undermines the mucosa, the edge of the crater still consists of tumor tissue, and this gradual blending is seen gastroscopically.

Figure 5 shows the x-ray picture, the gastroscopic picture and the gross specimen of an ulcer which at x-ray was considered to be malignant. At gastroscopy it was called benign because of its sharp edge, and it was proved to be benign at the microscopic examination of the gross specimen. The deceptive nature of the so-called therapeutic test is demonstrated on Figure 6. The large ulcer niche became rapidly smaller under medical treatment, yet gastroscopy, undertaken at the time of the first x-ray examination, revealed definitely a carcinomatous ulcer, as proved by the blending edge of the ulcer. (See Figure 7.) Operation proved the gastroscopic diagnosis to be correct. Quite a few such cases have been observed, and the so-called therapeutic test should be given up as too slow and unreliable. However, gastroscopy is not

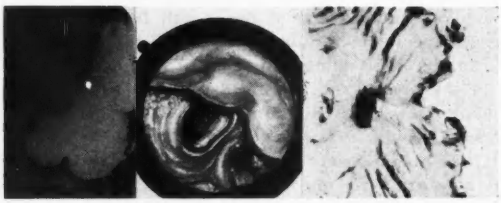

Figure 5.—*X-ray picture, gastroscopic picture and gross specimen of a benign ulcer.* At gastroscopy the benign nature of the deep ulcer was readily recognized because of its sharply cut-out margin.

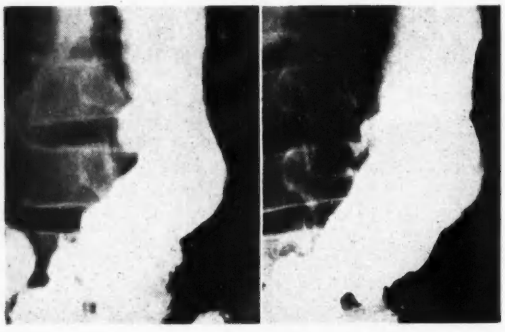

Figure 6.—*Deceptive nature of the so-called therapeutic test.* Under treatment the large niche of the ulcer shown at the left side of the picture became smaller (right side of picture). Nevertheless this ulcer proved to be a malignant ulcer.

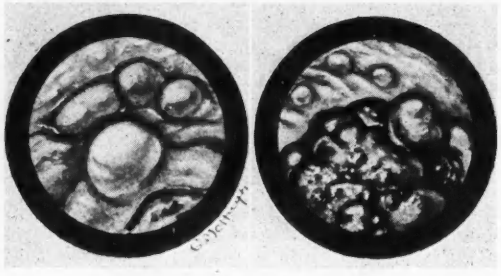

Figure 8.—*Polyps of stomach, a precancerous condition.* In the pictured case 25 polypous benign adenomas were observed, one of which had degenerated into a carcinoma. Left side of picture is the gastroscopic view of four of the benign polyps; right side of picture shows a gastroscopic view of the same case; three polyps are seen in the background (between 10 and 12 o'clock); the foreground is occupied by the large polypoid, ulcerated carcinoma.

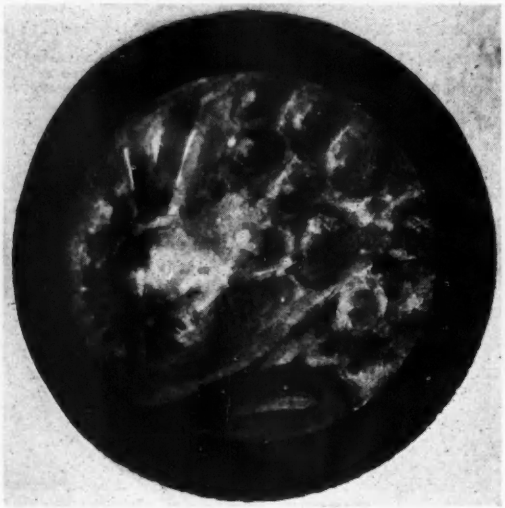

Figure 7.—*Gastroscopic picture of the ulcer shown in Figure 6.* The carcinomatous nature of the ulcer can be recognized at once because the right side of the ulcer floor (seen between center of picture and 9 o'clock) blends gradually with the surrounding infiltrated nodular mucosa.

Figure 9.—*Gastroscopic picture of the normal posterior wall of the stomach.* Regular complicated fold system. The brilliant orange-red color of the mucosa cannot be shown in the black and white reproduction.

infallible. At least three times I have made the wrong diagnosis of a malignant ulcer because of the exorbitant swelling in the surroundings of the ulcer. To the best of my knowledge the opposite mistake was only made once. Thus the important early differentiation betwen benign and malignant ulcer can be made with an astonishing degree of accuracy at gastroscopy, if the lesion does not lie in one of the well-known blind areas which cannot be seen gastroscopically.

The surgeon must realize now that x-ray examination and gastroscopy have attained such a perfection that lesions may be discovered so small that the palpating finger of the surgeon cannot feel them. In cases of such small lesions the surgeon should undertake resection, if both methods agree, or he should convince himself of the presence of the lesion by taking a look through the gastroscope himself.

There is a new hopeful approach for the finding of such small lesions, namely, discovery and observation of so-called precancerous conditions. Benign small polyps which certainly are a precancerous condition must be watched carefully in order not to overlook their growing and their development into malignancy. Figure 8 shows the gastroscopic picture of some of a total of 25 benign polyps, one of which had become malignant.

Much more important as a precancerous condition, however, is chronic gastritis, especially its atrophic form. Figure 9 shows the normal gastroscopic aspect of the gastric mucosa, which is orange red in color and presents regular folds without visible blood vessels. Figure 10 is the gastroscopic picture of extensive atrophic gastritis. The mucosa is thinned, greenish-gray in color, and submucosal blood vessels are visualized. Recently it has been proved beyond any doubt that gastric carcinoma is much more frequent in patients with pernicious anemia than in other people of the same age group. In pernicious anemia, atrophic gastritis almost always is present. Such cases have been observed carefully clinically and the diagnosis of very small carcinomas has become possible.

The same should be true, in my opinion, in uncomplicated atrophic gastritis. At least one-fourth

Figure 11.—*Gastroscopic picture of a large polypoid carcinoma having developed on the soil of atrophic gastritis.* Curve of the angulus is seen between 2 and 8 o'clock. Behind it (between center and 10 o'clock) the pylorus becomes visible. At bottom of picture, between 7 and 5 o'clock, the fold of the musculus sphincter antri is seen. Above it at right side of picture is the large elevation of the carcinoma.

Figure 10.—*Gastroscopic picture of atrophic gastritis.* The gastric mucosa is thinned, the glands are destroyed so that the large blood vessels of the sub-mucosa become visible; there are no folds. The greenish-gray tinge of the mucosa cannot be shown in the black and white picture.

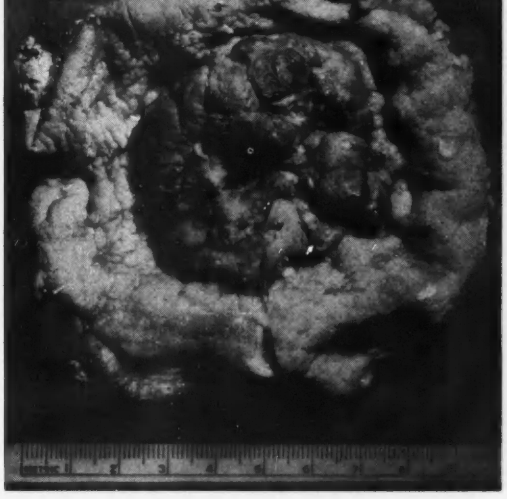

Figure 12.—*Carcinoma of the stomach developing on the soil of atrophic gastritis.* Same case as Figure 11. Gross specimen.

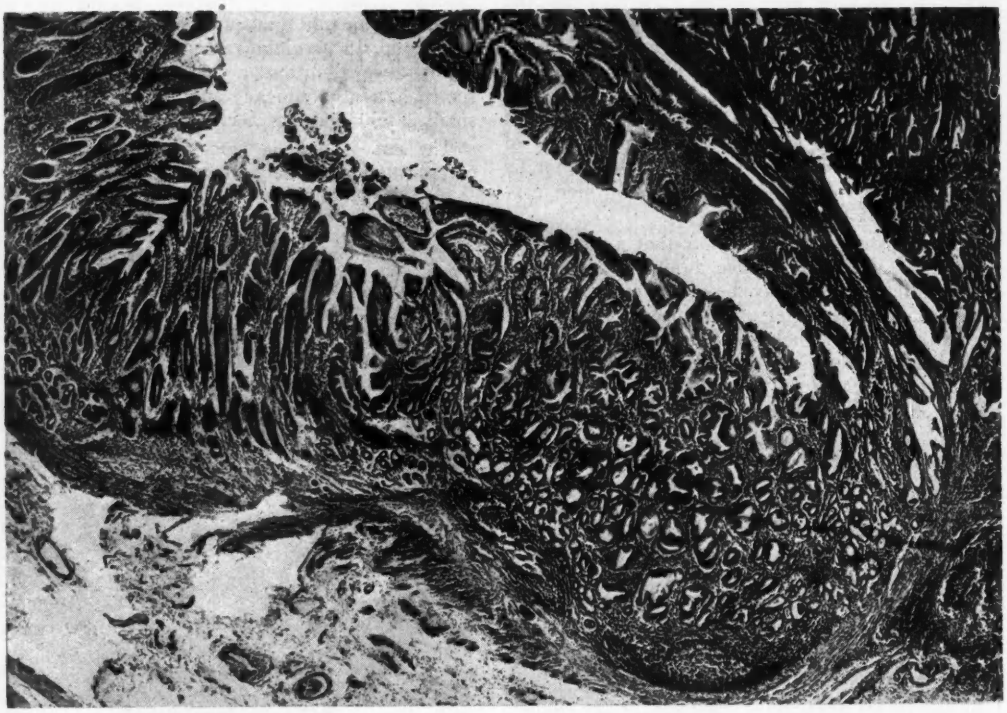

Figure 13.—***Carcinoma developing on the soil of atrophic gastritis.*** Same case as Figures 11 and 12. Photomicrograph of overhanging edge of tumor. At left side the typical picture of atrophic gastritis is seen. Disappearance of glands, interstitial infiltration, appearance of goblet cells; in center of picture there is formation of atypical tubules, from which the tumor (at right side of picture) originates.

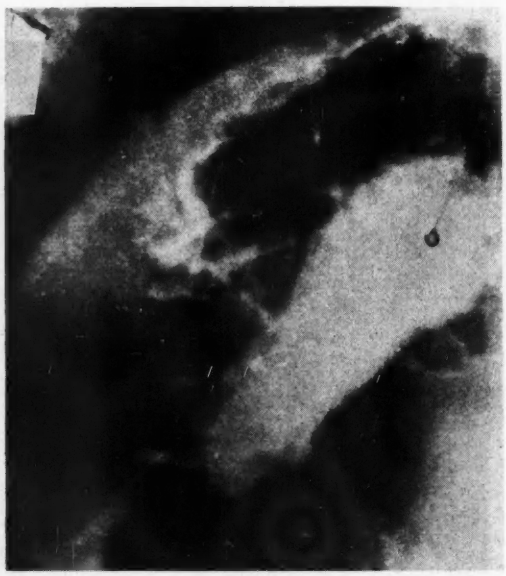

Figure 14.—***Small carcinoma of the pylorus found accidentally at routine re-examination of a patient suffering from atrophic gastritis.*** X-ray picture; a tiny niche is seen exactly within the pyloric ring.

Figure 15.—***Small carcinoma of the pylorus found accidentally at routine re-examination of a patient suffering from atrophic gastritis.*** Gastroscopic picture. The curve of the angulus is seen between 2 and 8 o'clock. The observer looks directly into the antrum. In the center of the picture is the distorted pylorus in which a whitish ulcer is visible. This ulcer was recognized at once as a small carcinoma. The atrophic nature of the mucosa of the antrum cannot be demonstrated in the black and white reproduction.

to one-third of all gastric carcinomas have not a short but a long case history—a case history of rather vague abdominal distress. These patients have been suffering from chronic gastritis. Thus a marvelous new approach to the early diagnosis of very small gastric carcinomas has been found. Atrophic gastritis can be discovered solely by gastroscopy. Once this diagnosis has been made, frequent re-checks by x-ray relief technique, with spot films, and by gastroscopy also, become necessary in order not to overlook the beginning gastric carcinoma which otherwise may grow symptomless for months or even years until it becomes inoperable. The exacting proof for the frequent development of gastric carcinoma from chronic gastritis is still missing, but so many rather convincing cases are observed that the possibility cannot be denied any longer.

Figures 11, 12 and 13 concern a patient who had suffered for 20 years from recurrent epigastric distress. After a gallbladder operation, histamine-proved anacidity pointing to atrophic gastritis had been observed for eight years. Then a small filling defect appeared and it was at first interpreted as a spasm. Gastroscopic examination (Figure 11) revealed a polypoid carcinoma lying in a distinctly atrophic mucosa. A resection was carried out. Figure 12 is a photograph of the gross specimen and Figure 13 a microscopic section through the edge of the tumor which shows distinctly the slow transition from the atrophic mucosa into the tumor tissue. A ten-year cure was obtained.

Figures 14, 15, 16 and 17 concern a patient who had been treated for atrophic gastritis. After a year, routine x-ray examination showed a tiny niche of the pylorus (Figure 14). At gastroscopy (Figure 15) a small, irregular ulcer within the pylorus was seen and the definite diagnosis of a very small pyloric carcinoma, together with atrophic gastritis, was made. The surgeon unfortunately was not able to feel the tiny lesion. He therefore made only a small resection instead of a subtotal gastrectomy, and the patient died two years later from metastases. Figure 16 is a microscopic section through the carcinoma. It is the smallest one I have ever seen, measuring 8 x 8 x 2mm.

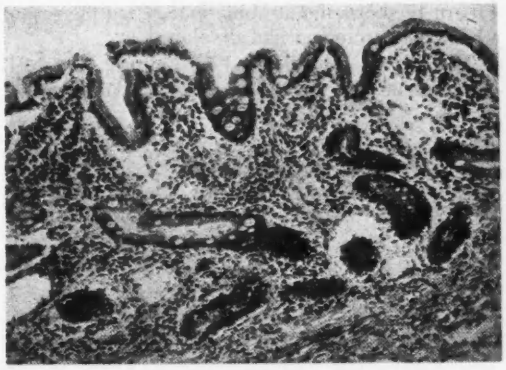

Figure 17.—Same case as Figures 14, 15 and 16. Photomicrograph of the antrum mucosa showing severe atrophic gastritis. All glands are destroyed; only residues of pits are left; there is interstitial infiltration and metaplasia of the epithelium of the surface and of the pits into an intestinal type of epithelium with many goblet cells.

Figure 18.—*Carcinoma of the upper posterior wall of the stomach found accidentally at gastroscopy only at the routine check of a patient suffering from pernicious anemia and atrophic gastritis.* Gastroscopic picture. Tumor wall with ulceration at the right side.

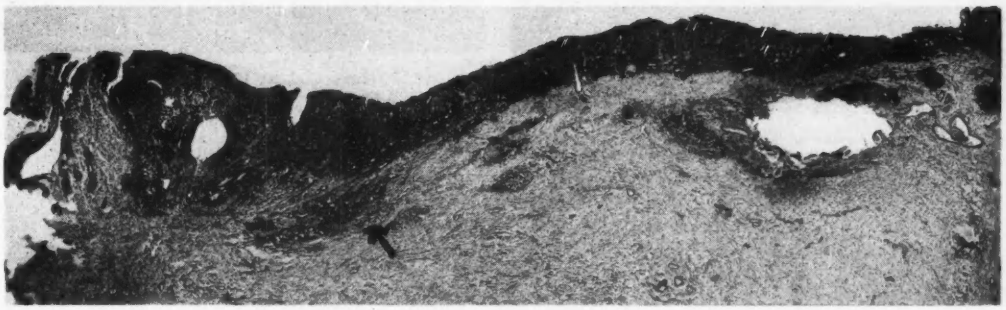

Figure 16.—Same case as Figures 14 and 15. Photomicrograph of ulcer floor. Small mucosal carcinoma. Its deepest penetration is indicated by an arrow. The carcinomatous tissue measured only 8 x 8 x 2mm.

Figure 17 shows the atrophic mucosa on the soil of which the carcinoma had developed.

The last case is pictured in Figures 18 to 21. The patient had pernicious anemia. At a regular re-check nothing was found at x-ray examination. At gastroscopy the thoroughly atrophic mucosa was seen and in the midportion of the posterior wall a carcinomatous ulcer was found (Figure 18). Figure 19 is a photograph of the gross specimen. The microscopic section of Figure 20 shows a well differentiated adenocarcinoma and Figure 21 is a photomicrograph of the severe atrophic gastritis of pernicious anemia on the soil of which this carcinoma had developed also.

Gastroscopy should lead to the frequent discovery of the precancerous conditions of polyps and of atrophic gastritis, and their careful observation should permit early discovery of very small symptomless carcinomas and, thereby, a substantial improvement in the prognosis of this disease.

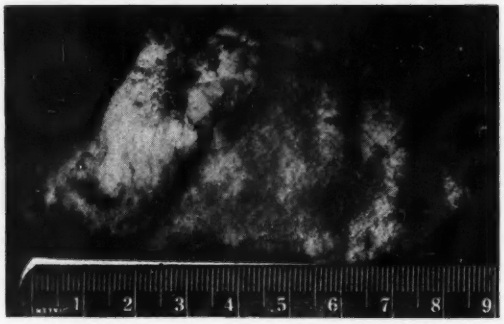

Figure 19.—Same case as Figure 18. Gross specimen. The tumor wall and ulcer corresponding with the one seen at gastroscopy is seen now lying in lower right corner of the picture.

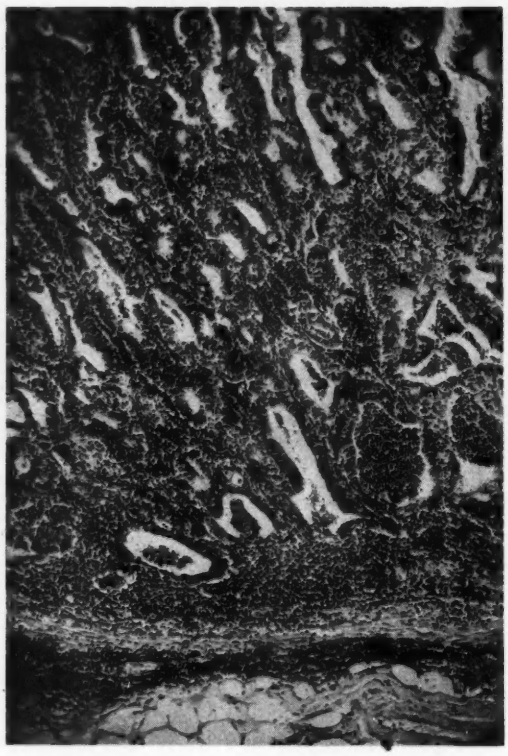

Figure 20.—Same case as Figures 18 and 19. Photomicrograph of the tumor showing a typical adenocarcinoma.

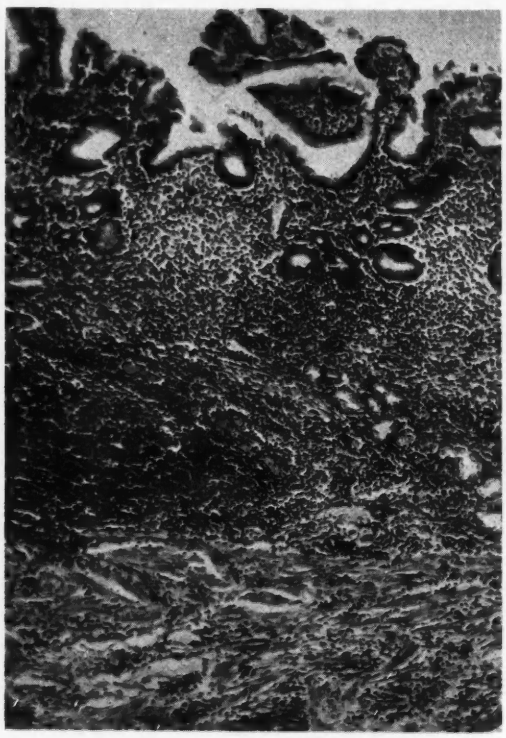

Figure 21.—Same case as Figures 18, 19 and 20. Photomicrograph of gastric mucosa. Severe atrophic gastritis. The glands are completely destroyed. Enormous interstitial infiltration. At the left side a much enlarged lymph follicle. Muscularis mucosae thickened, split-up and infiltrated.

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Problems in the X-Ray Diagnosis of Early Cancer*

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THE roentgenologist and the internist cannot view with complacency the fact that 75 per cent of patients with gastric cancer come to the surgeon too late for successful operation. There are several reasons for this.

First, the growth may be in a silent area of the stomach, remaining asymptomatic until the lesion has reached an inoperable stage.

Second, the cancer may be of such a malignant nature that it spreads very early to the neighboring lymph nodes and organs.

Third, delay in diagnosis due to the difficulties involved in differentiating between benign and malignant lesions of the stomach. This is especially true in those borderline cases in which the final expression of opinion should be in the hands of the tissue pathologist. The surgeon, the internist and, above all, the roentgenologist should remember the fact that the x-ray has no microscopic attachment.

The roentgen findings in carcinoma of the stomach are (1) the filling defect, (2) the palpable mass, (3) absence of peristalsis in the area of involvement, (4) lack of normal flexibility of the stomach wall, (5) alteration from normal in the stomach mucosa, and (6) disturbances in the motility of barium through the stomach.

The roentgen diagnosis of operable cancer simply means that the lesion probably is resectable. This is determined by the extent of the growth and its location, also by the mobility or fixation of the mass. The latter usually indicates its extension beyond the stomach wall. The presence of intra-abdominal metastasis cannot be determined by the roentgenologist.

Persistence on the part of the roentgenologist is important, especially in the presence of suspicious clinical symptoms and a final roentgen diagnosis of normal stomach should never be made until repeated studies have been done.

In the event of doubtful or indeterminate roentgen findings, and even with negative findings, in suspicious cases the stomach should be inspected by a gastroscopist.

Of major importance in this discussion are those cases in which the cancerous lesion develops on a previously diseased mucous membrane. Usually in these cases the patient has had gastric complaints for some time before the cancer has developed and in some of the cases the lesion may remain localized for several months or even years.

There are three separate groups of clinical entities on the soil of which cancer develops: (1) gastritis, (2) polyps, and (3) gastric ulcer.

1. *Gastritis.* It is in this group of cases that gastroscopy is of fundamental importance and the roentgen findings of little significance unless a fairly advanced cancer is present. Roentgen studies may show thickening of the gastric rugae with deposits of islands of barium, varying in size and shape. Roentgen evidence of stiffening of the stomach wall and absence of peristalsis in the area of involvement indicate probable malignancy.

2. *Polyps.* There are two types of polyps: The congenital and the acquired. The congenital may be single or multiple and pedunculated. They appear on the x-ray film as negative circular shadows. Of greater importance from the standpoint of the development of cancer is the acquired type of polyp which originates on the basis of gastritis. Gastroscopy and biopsy are the conclusive diagnostic methods in these cases.

3. *Gastric Ulcer.* Two types of malignant gastric lesions may masquerade as chronic benign ulcer. One is the small ulcerating carcinoma, and the other the carcinomatous ulcer. The latter is an ulcer with no evidence of tumor formation seen on the x-ray but which, on microscopic examination, proves to be a cancer. If the niche of the ulcer is large, if there is an absence of peristalsis and the adjacent rugae are obliterated, or if the margins of the niche have an irregular profile, the roentgenologist must consider the lesion as potentially malignant. In these cases the radiologist will express an opinion only on the physical characteristics of the lesion.

In ulcerating carcinoma, the cavity produced by the ulceration is within the confines of the gastric lumen. If the meniscus sign as described by Corman can be demonstrated, the lesion in most cases proves to be malignant.

St. Vincent's Hospital, Los Angeles.

* Presented as part of a panel discussion on Carcinoma of the Stomach at the Seventy-fifth Annual Session of the California Medical Association, Los Angeles, May 7-10, 1946.

Recent Advances in Surgical Treatment of Cancer Of the Upper End of the Stomach*

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THE surgical treatment of lesions of the cardiac end of the stomach and lower esophagus has been simplified and improved by the use of the transthoracic approach to these lesions. In this procedure the chest is entered through the left eighth interspace and the abdominal cavity is opened by incising the diaphragm above the esophagus. This incision is then carried down to the esophagus, and the stomach and lower esophagus are then freed and resected as indicated and a direct anastomosis performed between the esophagus and the distal portion of the stomach, which is pulled up into the thorax for this purpose.

Technically, the operation has proved feasible and does not involve too great a risk. The blood supply of the esophagus has proved ample to assure the healing of the anastomosis and the near term post-operative results have been excellent. In our own experience, the time elapsed and the small number of cases done does not enable us to draw any further conclusions.

This particular operation was first done successfully in one stage by Adams and Phemister in 1937. Since this time a number of authors have reported on the results of this operation. A number of small series have been recorded, and recently Sweet reviewed 127 cases in which the transthoracic approach was used. In 85 patients the lesion was in the stomach or lower esophagus. A resection was done in 61 patients; 24 cases were inoperable. The mortality was 19.5 per cent. Of the patients who survived, only three are alive and well three or more years post-operatively. Nevertheless, Sweet states that if after radical surgery the patient is relieved of his obstruction and can swallow again satisfactorily, if only for six months to one year, the operation should be considered worthwhile. We agree with this statement.

At Stanford University Hospital we have operated upon 16 patients with carcinoma of the esophagus and stomach by means of this approach. In nine patients a successful resection and anastomosis was done. Seven patients had inoperable lesions, but freeing the diaphragm around the growth enabled these patients to eat for a time following operation, which they had been unable to do previously. There were no hospital deaths in these 16 cases. One suspected case of carcinoma, which proved to be inflammatory, was resected. This patient died of a cardiovascular accident the day after operation and this was the only hospital death in the entire series of transthoracic operations. The transthoracic approach was used in five additional patients with benign esophageal lesions.

In four patients with megesophagus, a successful esophagogastrostomy was performed. We have used the transthoracic approach for malignant and benign lesions in 22 cases.

DEVELOPMENT OF THE OPERATION

The development and success of the operation are the result of three lines of effort. First and foremost has been the painstaking investigative and practical work over many years of the surgeons primarily interested in thoracic surgery. As long ago as 1871, Billroth demonstrated in animal experiments the feasibility of resection of the esophagus. In 1905 Sauerbruch performed experiments on cadavers consisting of transthoracic resection of the esophagus and its invagination into the stomach. Torek performed the first successful esophageal resection with indirect restoration of continuity. A long list of surgeons added their contributions in this field leading up to Adam's and Phemister's first successful one-stage resection with restoration of direct continuity between the esophagus and stomach in 1937. Since this time, the operation has been accepted rapidly as a standard procedure and many surgeons have reported their experiences with it. Among them are Ochsner and DeBakey, Garlock, Stephens, Sweet, Kay, Dorsey, Churchill and Clagett.

Coincident with the development of thoracic surgery and contributing largely to its present success has been the development of the art of anesthesia. Beginning with complicated and expensive positive pressure chambers up to the present simple method of intratracheal anesthesia, the anesthetists have simplified the problems of thoracic surgery and greatly lessened its complications. Beecher states that the transthoracic approach to upper abdominal lesions may produce, in fact, no more shock and perhaps even less than the trans-abdominal wall approach.

Finally, the introduction of newer forms of chemotherapy, notably the sulfa drugs and penicillin, in the last few years have greatly reduced the hazard of infection.

PREOPERATIVE CARE

As the patients are usually elderly and greatly undernourished, everything possible is done to improve their general physical state before operation. Blood transfusions and appropriate intravenous fluids are given, as well as vitamins. Sulfadiazine and penicillin are administered before surgery. It

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is important to wash and cleanse the esophagus thoroughly before operation.

OPERATION

The left pleural cavity is opened in the eighth or ninth interspace. The phrenic nerve is pinched to paralyze temporarily the diaphragm, and the latter is incised in its tendinous portion above the esophagus. The stomach is mobilized in the usual manner and this procedure is continued up the esophagus for a distance sufficient to get well above the growth. Mobilization of the stomach, and if necessary the duodenum, is an essential technical step in the operation, so that the distal portion of the stomach can be drawn into the thorax without tension for anastomosis with the esophagus. The anastomosis is made with chromic catgut and interrupted silk sutures. The cut end of the stomach is first closed and an end to side anastomosis is made between the esophagus and the fundus of the stomach. The incision in the diaphragm is closed around the remaining stomach, and the latter is fixed to the cut edges of the diaphragm with interrupted silk sutures. Fifty-thousand units of penicillin in 50 cc. of saline is left in the pleural cavity. A mushroom catheter is brought out in the tenth interspace and the wound closed.

POSTOPERATIVE CARE

Sulfadiazine and penicillin are continued as long as it appears necessary. The catheter is removed in 48 hours. The Levine tube is removed about the fifth day. The majority of patients have had a remarkably smooth convalescence. Pleural effusion, which disappeared after one or two tappings, appeared in a few cases. The patients are gotten out of bed early and they begin taking liquids by mouth 24 hours after the Levine tube is removed. Semi-solids and solid foods are added as tolerated, and none of our patients have had any difficulty in swallowing during their convalesence. There were no hospital deaths in the patients operated upon for carcinoma.

Of the nine patients in whom a carcinomatous lesion was resected, two died after a period of relief from symptoms; one in nine months and another in one and one-half years. A third was known to have metastasis six months after operation and has not been heard from since. He is presumed dead. Six patients are living after periods of one or two months to two years. All the patients in whom an inoperable lesion was found have had considerable temporary relief from their dysphagia.

This report and review of the results as given in the literature is not a hopeful one so far as ultimate cure is concerned. Nevertheless, the operation does furnish temporary relief for a varying period of time and offers the only present chance for cure in a previously hopeless condition.

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Radical Surgical Treatment of Gastric Cancer*

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THE greatest margin for error in reporting end-results for the treatment of gastric cancer may be found in the classification by the reporter of any given cancer of the stomach as operable or inoperable. The difficulty in correcting this fault is apparant when one realizes that three variable factors interplay in the pronouncement of any cancer of the stomach as inoperable by any given surgeon; *viz.*, first, the condition of the patient as regards his age, the coexistence of degenerative diseases and the complications attendant on the presence of the cancer; second, the extent of the disease, meaning the degree of involvement of the stomach, the extension to and incorporation of neighboring viscera by the cancer and metastases to regional and distal sites; third, the surgical philosophy, moral point of view, courage and experience of the surgeon.

In the large group of patients found to have generalized metastases or diffuse involvement of the liver and peritoneal lining, the recognition and acceptance of inoperability is obvious to any physician, but there are too numerous other instances in which the definition of inoperability may be subjected to careful evaluation, criticism and even condemnation.

THE POINT OF VIEW OF THE SURGEON

It is not our purpose to formulate a set of rules governing the behavior of any surgeon in a given circumstance, but rather to present just arguments for extending the scope of operability for gastric cancer. The very nature of this disease, the infirm and often aged patients in whom it so frequently develops, the radical character of the operations designed to combat it, all conspire to make the surgical treatment of gastric cancer a hazardous venture for the patient and often an ordeal for the surgeon. With a knowledge of the inevitability of death from cancer of the stomach that is not treated, it seems unnecessary to state that no surgeon would refuse a patient the slightest chance for cure or even relief because of a fear of criticism for failure or an unnatural pride in low figures for operative mortality. Nor should any surgeon attempt to play God and decide arbitrarily that a certain patient with gastric cancer had lived a sufficiently long life or that he had so few remaining years of even normal life expectancy that operation at best would hardly be worthwhile. We must take care, in our weighty decisions concerning the denial or offering of a chance for life to a patient, that in our desire not to be the executioner we do not achieve the same end-result by acting as an immoral judge.

About a decade ago Doctor Edward M. Livingston and I brought together for analysis and review the great body of published data on the treatment of carcinoma of the stomach recorded in the half century that had elapsed since the first successful resection by Billroth. For this purpose more than one thousand publications dealing with the subject were submitted to critical study. These represented as nearly as could be readily ascertained, a virtually complete list of the recorded gastric resections from the world literature. Proper deductions, as drawn from this material, therefore, offered the most reliable conclusions possible to obtain up to that date.

At that time answers were sought to a number of specific queries which naturally arose: What was the life expectancy for patients with untreated gastric cancer? What proportion of those having the disease were given an extension of life by medical, radiological or surgical care? What is the nature of a definitive cure? Was there evidence concerning the nature and tempo of progress during that time? Upon what factors was this progress dependent? What accounted for the failure to bring the benefits of excisional surgery to larger numbers? And to these might be added the further question: Was there reasonable hope, from facts and methods now known, of obtaining in the immediate future any materially larger number of definitive cures?

BASIS FOR STUDY OF END-RESULTS

Any study of end-results in the treatment of gastric cancer in terms of attained long-term definitive cures resolves itself into an analysis of surgical methods and their value. For such a study it was essential to determine three points: 1. The applicability of excisional surgery or the percentage of the total number afflicted with the disease for whom extirpation is feasible; 2. The risks involved in efforts to remove the carcinoma; and, 3. The effectiveness of gastrectomy when this can be successfully performed. These points correspond to three questions for which the patient with the disease urgently seeks an answer: 1. "Can the tumor be removed?" 2. "How much danger is involved in an attempt at its removal?" 3. "How certain will be the cure if I assume these risks and undergo the operation?" Decision as to advisability of attempting a gastrectomy in a specific case must hinge in large measure from these points; and the interpretation of the complete significance of the reported end-results is dependent upon them.

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† From the Gastric Service of the Memorial Hospital for Cancer and Allied Diseases, New York, N. Y.

The conclusions drawn from this study may be summarized here as representative of the conditions surrounding the diagnosis and treatment of gastric cancer in the United States a decade ago. This data is presented in order to draw a proper comparison with the progress that has been made in the succeeding ten years.

1. The average patient with untreated gastric cancer was dead within 12 months after the onset of symptoms or was dead within four months after discharge from the hospital.

2. Neither the size of the gastric neoplasm as revealed by clinical or radiological study nor the lapse of time since the onset of symptoms offered a reliable guide for an estimation as to operability, for the reason that bulky adenocarcinomas which fill a large portion of the gastric lumen, or slow-growing prepyloric tumors which have caused symptoms over relatively long periods, alike may offer an excellent prospect of long-term cure.

3. A satisfactory formula for the appreciation of attained cures of gastric cancer may be applied to any group of patients seen in any hospital or clinic as follows: Cures equal the total number of patients observed, minus the number of patients found to have inoperable gastric cancers, minus the number of patients operated on but found to have unresectable gastric cancers, minus the operative mortality or number of patients dying after resection of the cancer and minus the number of patients dying in the three-, five- and ten-year postoperative periods after which definitive cures become possible. The number and size of each of these loss factors precluded in 1936, and apparently for some time in the future, the attainment of large percentages of long-term cures from *all patients* seen.

4. It was apparent from the relations of this cure formula that cancer of the stomach was not exclusively a surgical disease, for the role in deciding for or against operation was shared with the medical attendant, the radiologist and others. The role of the medical attendant may exceed that of the surgeon in practical significance, since the hospital service with high rates of operability will obtain more resultant cures with even inferior grades of surgery than will a hospital service with low rates of operability, no matter how excellent the surgical associates.

5. Resectability or non-resectability is often ascertained with complete certainty only through surgical exploration. Laparotomy is here to be viewed as but a form of internal palpation; thus the resultant cure should not be measured solely against the total number of operations performed, for these include the management of a large number of surgically non-curable types of the disease.

6. To perform a gastro-enterostomy or other temporizing or palliative procedure for a resectable gastric cancer is unwarranted because no author had reported (by 1936) an average extension of life from gastro-enterostomy of more than two months and the operative mortality for gastro-enterostomy for cancer was as great as the operative mortality for attempted resection of a malignant tumor of the stomach. The life lost from immediate death following gastro-enterostomy for cancer exceeded the total life extension gained among survivors, and any advantages of palliative gastro-enterostomy were not to be measured in terms of life extension but in terms of symptomatic relief alone.

7. The cure formula for resectable gastric cancer is: cures equal resections performed, minus operative mortality, minus natural rate of post-resection decline in survivors. It was noted that the patient with resectable gastric cancer had two hazards: the resection risk and the post-resection death rate from recurrence or natural death. The former hazard was under surgical control while the latter rested largely in the hands of nature and could be but little influenced.

8. Responsibility for establishing proper conditions for gastric cancer surgery is largely an institutional problem; it is an ethical principle that institutions admitting patients with this disease in numbers should provide for their concentration in proper surgical hands, allow for the use of special surgical teams, and furnish the necessary special equipment.

9. No surgeon who is unqualified, or who has not the full intent to resect a gastric carcinoma if a resectable tumor is encountered, has the moral right to operate on a patient with gastric carcinoma.

10. Resectable gastric cancer is a numerically common condition, for necropsies have revealed that even at the time of death from gastric cancer approximately one-fourth of these tumors were still confined to the stomach or to the stomach and immediately adjacent lymph nodes.

11. The operability rate may be referred to as the hospital or community index, while the resectability rate may be referred to as the surgical index. These two indices either alone or in combination define the resultant cures attained and a low index in either case will identify the cause of a low rate of resultant cures and reveal whether the medical or the surgical standards should be held accountable.

12. In 1936 it was estimated that from two-thirds to three-fourths of gastric cancers were unresectable from the time when first seen at the hospital or clinic. For approximately 60 to 75 per cent of patients with this disease, surgery offered not the faintest hope for cure.

13. With only three exceptions, no American clinic in the historical range of surgical therapy until 1936 had ever reported more than a total of 100 gastrectomies for cancer.

14. Except where gastric resections were performed by specially trained surgeons or surgical teams working under ideal conditions, the operative mortality was excessive and definitive cures proved numerically few. The resection mortality before 1936 in surgical centers performing large numbers of gastrectomies for cancer averaged 17 per cent while that for the casual surgeon or in

clinics reporting small numbers of resections was found to average approximately 30 per cent.

15. Where malignant tumors were still confined to the stomach at the time of gastrectomy, the five-year cures reached as high as 50 per cent of all patients upon whom resection was performed.

16. At no time in surgical history up to 1936 and at no point in the world had the definitive cures of gastric cancer ever exceeded 5 per cent of the total number of patients with the disease.

17. Approximately one-third of the immediate survivors of gastric resection for cancer were alive at the end of three years; one-fourth were living at five years; one-fifth living beyond ten years from the time of hospital discharge.

18. The percentage of long-term cures for resectable cancer equaled or exceeded that obtained in the treatment of cancers of the tongue, cheek, tonsils, thyroid, brain, lung, esophagus, intestines, gall bladder, liver, prostate, ovary, and many other varieties of malignant neoplastic diseases.

CULPABILITY FOR DELAY

In another statistical study published ten years ago Dr. James S. Gallo and I revealed that in a thousand patients with cancer, the culpability for delay in establishing early diagnosis and instituting early and appropriate treatment, was the fault of the patient in two-thirds of the instances, but the fault of the physician first consulted in the other third. It was mandatory at that time that the educational efforts should be directed not only toward the layman who was entering the age at which gastric cancer might occur, but also to the general practitioner who usually encounters the patient at the time of the first complaint of indigestion.

In an effort to detect early gastric cancers even before symptoms become apparent, several studies have been made in the form of elective radiographic examinations of stomachs of apparently well people in the cancer-bearing age. Dr. Fordyce B. St. John and associates found three unsuspected gastric cancers in a consecutive series of 2,400 such x-ray examinations. As an effort to increase the salvage of patients with this disease one might compare the possibilities offered by an increase in the radical nature of gastric surgery which has occurred largely through the same decade. For example, cancers of the gastric cardia which were formerly considered inoperable because of their location in the stomach, may now be removed either by total gastrectomy via the abdominal route or by transthoracic, transdiaphragmatic cardiectomy with an intrathoracic esophago-gastrostomy. If these procedures were routinely done for patients with cancers in the gastric cardia it would offer 150 out of 2,400 patients with the disease an opportunity, at least, for cure.

REASONS FOR IMPROVEMENT IN END-RESULTS

The great improvement in end-results in the treatment of gastric cancer which has occurred during the past decade cannot be attributed to any studies dealing with the etiology of the disease. The betterment may be attributed to four factors, namely:

1. An improvement in the earlier diagnosis of gastric cancer due to increased alertness on the part of the public through education on cancer and through better medical facilities for the recognition of the disease in the patient.

2. A greatly increased number of surgeons in the United States are now qualified to perform the usual subtotal gastrectomy for cancer, in consequence of which the operation has much wider employment with the extension of the possibilities of cure to many more people.

3. The patient has been made infinitely safer for the surgical treatment of gastric cancer by improvements in pre-operative and post-operative care. Metabolic deficiencies existent in the patient with gastric cancer, such as impairment of liver functions, disturbances in the fluid and electrolyte balance and the almost constant hypoproteinemia with the many complications which follow this condition, are now generally recognized and the means of treating them are readily available and understood. Chemotherapeutic measures have been responsible for the lessening of complicating infections. Wound disruption is an extremely rare occurrence and early ambulation of the patient lessons the mortality from such complications as pneumonia, thrombosis, embolism and cardiovascular collapse.

4. The extension of radical surgery in the treatment of gastric cancer has increased the scope or possibility of cure for many additional patients. The evolution of these surgical techniques has taken place largely in the past decade. Extension of radical surgical treatment of gastric cancer has progressed in three ways:

(A) By the bold sacrifice of adjoining or contiguous viscera that may be involved by the gastric cancer. For example, in addition to the gastrectomy, segments of the left lobe of the liver, pancreas, the spleen and the transverse colon are frequently removed. These adjacent organs are sometimes so intimately adherent to the cancerous segment of the stomach as not to be separated from them by dissection; a removal with the diseased segment of the stomach increases the possibilities for cure.

(B) The removal of the entire stomach if the cancer involves the major part of the organ or has metastasized to lymph nodes extending along either the lesser or greater curvature of the stomach to such an extent that a wide margin of excision cannot be done safely with preservation of any portion of the organ.

(C) For those cancers of the gastric cardia that involve the abdominal esophagus or extend into the thoracic esophagus, the surgeon may extend an abdominal incision intercostally into the thoracic cavity and by transsecting the diaphragm convert the thorax and abdomen into a single cavity in which the resection of the esophagus and stomach

may be performed with reconstruction of gastro-intestinal continuity by an intrathoracic anastomosis.

TOTAL GASTRECTOMIES FOR CANCER

In the Gastric Service at the Memorial Hospital we have performed approximately 50 total gastrectomies for cancer. The operation includes a removal not only of the entire stomach, but of the adjacent lymph node-bearing regions as well, which includes all the lymph nodes along the lesser and greater curvatures of the stomach, the greater omentum in its entirety, the parapyloric and retropyloric lymph nodes as well. In some instances the peritoneum of the lesser omental bursa is stripped off with the specimen. The duodenal stump is closed and the abdominal esophagus, after mobilization, is used for anastomosis to a loop of jejunum. The jejunal loop is brought up either in front of the colon or through the mesocolon to effect an end-to-side anastomosis with the esophageal stoma. The anastomosis is fortified by suturing a flap of diaphragmatic peritoneum anteriorly and posteriorly below the suture line in order to suspend the jejunum and to give additional strength to the anastomosis. A lateral anastomosis or entero-enterostomy is done in order to provide a short-circuiting of the bile and pancreatic juice between the proximal and distal jejunal limbs and in order to provide a suitable egress for any food when swallowed which enters the proximal jejunal limb.

The operative mortality for total gastrectomy is 20 to 30 per cent as compared with 8 to 12 per cent for subtotal gastrectomy. The chief complications of the operation have been of pulmonary origin rather than infections in the peritoneal cavity. These patients have certain metabolic deficiencies during the post-operative state but this has not been a great handicap to the individual patient. After proper time for adjustment the jejunal loop serves most satisfactorily as a substitute stomach and the patient usually can enjoy a full meal without appreciable discomfort. The organ is not essential for life and such a complication as severe anemia is not encountered as frequently as one might have anticipated in view of the important role this organ ordinarily plays in hematopoiesis.

CANCERS INVOLVING THE GASTRIC CARDIA

The 8 to 10 per cent of patients with cancers involving the gastric cardia are no longer classified as incurable because the surgeon has not been able to pursue an upward exposure of the cancer-bearing segment to include the cardiac end of the stomach and the abdominal and thoracic esophagus so as to carry the resection high and thereby insure complete removal of the tumor and the adjacent lymph nodes. Dr. William Welch in his classical chapter on Cancer of the Stomach in Pepper's Textbook of Medicine, published three years after Billroth performed the first successful gastrectomy in humans in 1881, established certain criteria for the successful resection of gastric cancer, one of which was that the neoplasm should not extend beyond the stomach proper. A half century elapsed before this dictum was corrected and surgeons elected to remove a liberal segment of the esophagus by the combined abdominal and thoracic approach.

A small exploratory upper left midrectus incision is made in order to ascertain the presence or absence of hepatic and peritoneal metastases, the extension of the cancer to regional lymph nodes, the mobility of the cancer and the amount of distal uninvolved stomach available for subsequent anastomosis. If the exploratory findings warrant the continuance of the operation, the incision is then extended upward through the costochondral cartilages and laterally in the seventh intercostal space to intercommunicate the thoracic and abdominal cavities. The diaphragm is split in a radial direction down to and including the crura. The stomach and terminal esophagus are mobilized in the usual surgical fashion and the cancer-bearing segment is widely excised. If the distal half of the stomach is normal it may be mobilized and drawn into the chest for anastomosis with the severed end of the esophagus. This union is accomplished by an end-to-end type of layer closure supplemented usually by a free omental graft to insure protection for the line of sutures. In three instances a total gastrectomy was done by this route and the jejunum was then brought into the chest and anastomosed with the esophagus, in one instance by an end-to-side anastomosis supplemented by an entero-enterostomy and in two other instances by the Roux en-Y technique whereby the distal end of the severed jejunum was anastomosed to the esophagus within the chest and the proximal jejunal end was anastomosed by an end-to-side procedure with the distal jejunal limb at a lower level so that no regurgitation of bile and pancreatic juice occurred into the thoracic segment of the esophagus. The diaphragm is repaired by suture and the patient usually receives immediately a high caloric, high protein diet by means of an orojejunal tube passed through the anastomosis into the jejunum.

The exposure afforded by this technique is excellent and the technical difficulties are not great. The operative mortality is in the neighborhood of 20 per cent, but this figure can be explained by the fact that the operation is offered to aged patients, many of whom have cancers of the gastric cardia. In the Gastric Service at the Memorial Hospital this operation has been performed on approximately 50 patients during the past four years. Some of the early patients are still living and free of evidences of recurrence. Another indication of improvement in the surgical treatment of gastric cancer may be appreciated when we state that the resectability of cancers of the gastric cardia in our experience has increased to 58 per cent of the total number of patients subjected to laparotomy or thoracotomy.

CONCLUSIONS

Improvement in the end-results in the treatment of gastric cancer may be attributed to a greater awareness on the part of the general public, improved facilities for the diagnosis of cancer, a wider application of surgical resection by an increased number of surgeons who are performing the operations in numerous hospitals throughout

the United States, and finally by the introduction of extremely radical surgical procedures. These radical surgical procedures are of three types:

1. The removal of the organs adjacent to the stomach that are involved by contiguity with the cancer.

2. Total gastrectomy when the cancer involves the major part of the stomach.

3. Transthoracic, transdiaphragmatic cardiectomy for cancers involving the gastric cardia.

Although the operative mortality for the major procedures is greater than for the simple subtotal gastrectomy, the number of total patients salvaged from those having the disease is inevitably increasing. Added to this are the advantages occurring from a better appreciation of proper pre-operative and post-operative care of the patient and the more widely disseminated knowledge of the metabolic disorders coincident with and related to gastric cancer.

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Use of the Thymol Turbidity Test as an Aid in Diagnosis of Dysfunctions of the Liver

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WHEN serum from patients with liver disease is added to a barbital buffer saturated with thymol, turbidity is produced. This was observed by Maclagan[1,2] in 1944, and he gave the name, thymol turbidity test, to this reaction. Maclagan used this test as an index of parenchymal dysfunction of the liver. The degree of turbidity apparently varied with the degree of hepatic parenchymal damage. An analysis of the precipitate demonstrated that it contained globulin, phospholipid, cholesterol, and thymol. The mechanism of the action is unexplained, but there is some evidence that the reaction may be due to an abnormal globulin released into the blood stream in the presence of damage to the liver. This disturbance in the serum globulin fraction does not involve primarily the gamma globulins[4] which tends to differentiate the mechanism of the test from that of the cephalin-cholesterol flocculation test. The thymol turbidity test does not test any known function of the liver, and thus should be regarded as an indicator of disturbed liver metabolism rather than as a function test.

METHOD

Reagents. Thymol-barbital buffer. A barbital buffer of pH 7.8, saturated with thymol is prepared as described by Maclagan:[2] 1.03 gm. of sodium barbital, 1.38 gm. of barbital, and 3.0 gm. of powdered thymol crystals are placed in a 1,000 cc. Erlenmeyer flask. Five hundred cubic centimeters of distilled water are added and the solution is heated to the boiling point. The flask is removed from the flame and the contents mixed well by shaking. The solution is cooled to room temperature. On cooling, the solution becomes turbid. A small quantity (approximately 0.2 gm.) of powdered thymol crystals is added and the solution again mixed by shaking. The flask is stoppered and kept over night at room temperature. Thymol crystals form at the bottom of the flask. After standing over night, the solution is mixed once again by shaking, and is freed of crystalline deposit by filtration. The clear solution is used as the reagent and may be kept indefinitely at room temperature.

PROCEDURE

The tests in this series were carried out with a slight modification of the procedure described by Shank and Hoagland.[5] These authors recommend adding 0.05 cc. of serum to 3.0 cc. of thymol barbital buffer in a cuvette. Readings were made by them in a Coleman, Jr. spectrophotometer. In this series, 0.1 cc. of serum was added to 6.0 cc. of thymol barbital buffer in a cuvette. The contents of the cuvette were shaken well and after standing for 30 minutes the turbidity was determined in the Klett-Summerson photoelectric colorimeter. The readings were made using a red filter which has a wave length of 660 mu. The galvanometer was adjusted to 100 per cent transmission of light with a blank containing 6.0 cc. of thymol barbital buffer.

The turbidity of the unknown serum plus the thymol barbital buffer is expressed in units derived from a standard curve prepared by the use of barium sulfate suspensions.

This curve serves as the means of calculating the turbidity units of any given reaction between the unknown serum and the thymol barbital buffer.

By using the red filter in the Klett-Summerson photoelectric colorimeter, the interference of the absorption spectrum of hemoglobin resulting from hemolysis of the red blood corpuscles and of bilirubin which may occur in high concentration in the serum of patients with hepatic disease, is eliminated.

The turbidity standards are prepared by the method described by Shank and Hoagland.[5] Three cubic centimeters of 0.0962 N barium chloride solution is diluted to volume in a 100 cc. volumetric flask by the addition of 0.2 N sulfuric acid at 10°C. At this temperature the particle size of the precipitated barium sulfate is such that a comparatively stable suspension results. A 5 unit turbidity standard is prepared by adding 4.65 cc. of 0.2 N sulfuric acid to 1.35 cc. of the barium sulfate suspension in the standard Klett-Summerson cuvette. A 10 unit standard is prepared by adding 2.7 cc. of 0.2 N sulfuric acid to 3.3 cc. of the barium sulfate suspension. A 15 unit standard is prepared by adding 1.85 cc. of 0.2 N sulfuric acid to 4.15 cc. of the barium sulfate suspension, and a 20 unit standard is prepared by adding 0.6 cc. of 0.2 N sulfuric acid to 5.4 cc. of the barium sulfate suspension. At room temperature there is some tendency for the barium sulfate suspension to settle out, and for this reason the cuvettes should be well agitated just before readings are made in the photoelectric colorimeter. If a cuvette containing 6.0 cc. of distilled water is used as a blank, there is a straight line relationship between the optical density of various dilutions of the barium sulfate standard at 660 mu. (Figure 1).

RESULTS

1. *Presumably normal adults.*

In 60 presumably normal adults in this series the average turbidity was 2.4 units. In none of these was the thymol turbidity more than 5 units nor less than 1 unit. Normal values as given in the literature are 0 to 5 units.[1,2,3]

2. *Infectious hepatitis.* (Included in this group are

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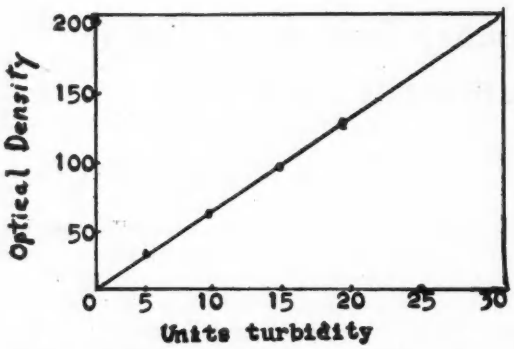

Figure 1.—Turbidity of barium sulfate suspensions as determined in the photoelectric colorimeter.

cases of "catarrhal jaundice" occurring in epidemic form in young adults.)

Significantly positive results were obtained in all of the 16 cases of acute infectious hepatitis studied in this series, showing an average of 16.8 units. In comparison with the bromsulfalein dye excretion test, icterus index, and cephalin-cholesterol flocculation test, the thymol turbidity was the last test to show positive results, and also, perhaps of more importance, was the last reaction to become negative. Because of the simplicity and rapidity, the thymol turbidity is an ideal test for serial determinations in infectious hepatitis, and, correlated with clinical evaluation, is perhaps the best indicator as to when to allow a patient with this disease to increase his activity.

It was observed in a group of Navy and veteran patients that, once the results of the thymol turbidity test became negative, and remained so for at least three weeks, heavy exercise did not cause any elevation in the number of turbidity units, or return of any clinical symptoms. In a similar group of patients, in whom the results of three consecutive thymol turbidity tests had been negative over a period of three weeks, the thymol turbidity units became elevated and clinical symptoms returned when these patients were given "liberty"; also a definite amount of liver tenderness was observed. In each case this liberty entailed poor dietary habits, plus a rather excessive use of alcohol over a five to ten day period.

It was further observed that in the cases of acute infectious hepatitis which went into the chronic hepatitic stage and in which ascites developed, the thymol turbidity reaction was even more markedly positive than in uncomplicated infectious hepatitis. An average of 21.5 units was obtained on initial determinations in these patients.

3. *Cirrhosis.*

Thymol turbidity tests were run on 36 cases of different types of cirrhosis. Seventy-five per cent of cases of cirrhosis fell within the "cirrhosis range" of 6 to 12 turbidity units.

The lowest determinations were found in all five cases of "alcoholism" with early fatty livers. Readings of 5 and 5.5 units were obtained in all of these patients. None of these patients had had any previous complaints referable to the liver or gastrointestinal tract.

Two of the three patients with turbidity values over 12 units died seven and ten days, respectively, after the tests were run. Autopsy studies in both of these cases revealed a typical advanced Laënnec's cirrhosis. In the third patient with a thymol turbidity value over 12 (14 units), liver biopsy revealed a toxic cirrhosis. Bromsulfalein dye excretion in the latter patient showed 20 per cent retention in 45 minutes and 8 per cent retention in 60 minutes (normal 10 per cent in 45 minutes and less than 5 per cent in 60 minutes).

4. *Other conditions producing hepatomegaly or jaundice.*

In six of seven cases of cardiac decompensation with congestive failure and markedly enlarged livers, normal values were obtained. In the seventh case, the determination fell in the "cirrhosis range," namely 7.5 units. This patient had 12 hospital admissions for congestive failure over a period of eight years, and on each admission a markedly enlarged liver was observed. He could perhaps be classified as a case of "cardiac cirrhosis."

In three cases of obstruction of the common bile duct, normal results were obtained with the thymol turbidity test, as also in three patients with cholecystitis and in one patient with an empyema and rupture of the gallbladder.

In three cases of thyrotoxicosis plus hepatomegaly, values of 8, 9, and 10 turbidity units, respectively, were obtained. These cases were considered to have cirrhosis in addition to the thyrotoxicosis. Following control of the thyrotoxicosis, the thymol turbidity units became lower, but remained elevated.

In two cases of disseminated lupus erythematosis, markedly elevated turbidity values were obtained.

5. *Carcinomatosis.*

Thymol turbidity tests were done on nine patients with abdominal carcinomatosis with hepatomegaly, or jaundice, or both. The diagnosis was confirmed by surgical exploration. In all cases without any gross evidence of hepatic metastases, normal values were obtained. In cases with gross involvement of the liver, the elevation of the thymol turbidity test corresponded to the degree of involvement. In all patients with gross hepatic metastases, the icterus index was 50 units or higher, and in two patients it was 154 and 170 units, respectively.

It is the opinion of the author that the thymol turbidity test may be very helpful in arriving at the diagnosis in patients in whom the onset of painless jaundice is rapid. Markedly elevated values are obtained in cases of acute infectious hepatitis and normal ones in carcinoma of the head of the pancreas unless long-standing biliary tract obstruction has been present or extensive metastases to the liver have occurred.

TABLE 1.—*Results in Thymol Turbidity Reactions in 60 Normal Subjects and in 120 Patients with Hepatomegaly and/or Jaundice*

	No. of Cases	Units of Thymol Turbidity 0.0–2.5	2.5–5.0	5.0–7.5	7.5–10	10–12.5	12.5–15	15–20	20–25	25–30	30–35	Mean
Normal	60	36	26	0	0	0	0	0	0	0	0	2.4
Acute infectious hepatitis	16	0	0	0	0	1	2	9	4	0	0	16.8
Chronic hepatitis	11	0	2*	1†	0	0	0	2	4	0	2	21.5
Homologous serum jaundice, convalescent stage‡	13	0	1	6	6	0	0	0	0	0	0	7.2
Cirrhosis	36	0	0	17	9	7	3	0	0	0	0	8.5
Congestive failure	6	0	6	0	0	0	0	0	0	0	0	4.0
Biliary tract disease	4	0	4	0	0	0	0	0	0	0	0	4.75
Carcinoma of the head of the pancreas without metastases	4	1	3	0	0	0	0	0	0	0	0	3.4
Carcinoma of the head of the pancreas with metastases	3	0	0	0	0	2	1	0	0	0	0	12.5
Disseminated lupus erythematosis	2	0	0	0	0	0	0	2	0	0	0	16.7
Miscellaneous§	25	0	16	5	2	1	0	1	0	0	0	4.9

* Tests run six months after all symptoms subsided. † Chronic hepatitis following infectious mononucleosis; test run three months after acute onset due to persistence of symptoms. ‡ All tests run two to three months after onset of acute symptoms. § Cases in this group included lymphomas, syphilis, pellagra, beriberi, infectious mononucleosis, amebic hepatitis, pernicious anemia, and diabetes.

SUMMARY AND CONCLUSIONS

In this series of cases the thymol turbidity units were markedly elevated in chronic hepatitis with ascites. The mean in the group of 16 patients with acute infectious hepatitis was 16.8 units, and the mean in the group of eight patients with chronic hepatitis with ascites was 21.5 units. The first determination in the acute phase of all cases of infectious hepatitis showed thymol turbidity values over 12 units, and under 30 units.

In 75 per cent of all cases of cirrhosis, the values fell within the "cirrhosis range" of 6 to 12 units. The lowest values (5 and 5.5 units) among the patients with cirrhosis were obtained in those with a definite history of alcoholism and early fatty livers.

In cases of hepatomegaly associated with cardiac decompensation, normal values were obtained in six of seven patients. In the seventh case, a value of 7.5 units was found, but this patient had had 12 hospital admissions for congestive failure in the past eight years. Therefore, unless there have been repeated liver insults, normal values may be expected in patients who have a large liver associated with congestive failure.

In extrahepatic biliary obstruction due either to a common duct stone, to carcinoma of the head of the pancreas, or to biliary tract carcinoma, normal values may be expected unless (1) the obstruction be of such long standing as to produce secondary liver damage, or (2) there be extensive metastases to the liver.

The thymol turbidity test of Maclagan, as modified by Shank and Hoagland, may be a useful adjunct in the differential diagnosis of extrahepatic and intrahepatic block, and because of its simplicity and rapidity, it should prove to be a valuable test in following the course of various types of hepatic and biliary tract disease. The results of the test can be reported to the physician within one hour after the blood is drawn from the patient. In a somewhat similar test that measures disturbed liver metabolism, the cephalin-cholesterol flocculation test, a 48-hour period must elapse before the results can be reported.[6]

The chief value of the thymol turbidity test at the present time appears to be for serial determinations in infectious hepatitis. Another very important feature is the usefulness of the test as a yardstick in determining the length of convalescence in this disease. Because of the fact that the thymol turbidity test is the last test of liver dysfunction to show negative findings in infectious hepatitis, it should be incorporated as one of a panel of liver function tests routinely performed in studying causes of hepatomegaly and jaundice.

In this series of 120 cases it was found that the degree of turbidity in the thymol turbidity test varied with the degree of hepatic parenchymal damage. For this reason the thymol turbidity test may be used as an index of parenchymal liver dysfunction.

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Physiological Basis for the Treatment Of Intractable Asthma*

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SOME years ago Dr. Chevalier Jackson coined a phrase which has become a medical cliche: "All is not asthma that wheezes." He implied that much wheezing goes on that is not asthma. To this the author would like to take exception. To the practicing physician everything that wheezes is asthma. To him, asthma means wheezing. Wheezing means bronchial obstruction. Therefore, asthma and bronchial obstruction are synonymous.

Bronchial obstruction may be due to many causes — new growths, congenital abnormalities, foreign bodies, swelling of the bronchial mucosa, mucous secretions, bronchospasm and so on. New growths, congenital abnormalities and foreign bodies may in themselves cause mechanical obstruction. Swelling of the bronchial mucosa, mucous secretions and bronchospasm are usually secondary obstructions.

The bronchi respond to irritation with a defense mechanism. The purpose of this mechanism is to prevent the entrance of noxious agents, or to dilute or get rid of them. In the lower respiratory tract this reaction represents what laryngospasm represents in the upper respiratory tract, namely, a protective mechanism. In the lower respiratory tract it is characterized by bronchospasm, the outpouring of mucous and coughing.

This protective mechanism can be initiated by an allergic reaction, an infectious reaction or a mechanical one. No matter which it is, we call it bronchial asthma. In other words, all asthma is the result of obstruction of the respiratory tract. But the initiating cause may come from a mechanical factor — as a growth — or it may come from an irritating stimulus, allergic, infectious or otherwise.

Many irritants may set off the asthmatic defense pattern. Two, however, are most common: One, the allergic antigen-antibody reaction and, two, infection. The allergic reaction is by far the most common, so common in fact that the term bronchial asthma is too often taken to mean only allergy. It was this unfortunate identification that impelled Jackson to coin his famous phrase implying that, to many people, wheezing means only one thing — allergic asthma. In allergic asthma the antigen-antibody reaction acts as the precipitating irritant which sets off the bronchial defense mechanism. In infectious asthma the asthmatic response is due to the infection *per se* which acts as the precipitating irritant setting off the defense mechanism in the same way that allergy does. It is not set off by an allergy to the bacteria causing the infection.

Infection may cause asthma in any age group. But among older people the onset of pulmonary emphysema creates an added susceptibility to infection. When pulmonary emphysema is present, it not only impairs respiration, it also impairs the ability of the bronchi to rid themselves of secretions and debris. This increases the susceptibility to recurrent and chronic infection. Infection destroys the ciliated epithelium of the bronchial mucosa. It also makes the bronchial walls thick and rigid. Thus a functional bronchiectasis is produced. The accumulation of foreign matter may then act as an irritant, precipitating the asthmatic attack.

Among younger people, the same sequence of events may follow. But the development of pulmonary emphysema comes not as the result of senile changes but as the result of persistent allergic asthma. In other words, allergic asthma often produces irreversible pulmonary emphysema. The allergy may then disappear. The emphysema, however, persists and becomes responsible for the asthmatic attack. Actually, the allergy has become a part of the past history. It no longer functions as the present cause.

THEORY OF NEUROSIS

Even though both allergy and infection may call forth an asthmatic response, it is well known that many individuals have respiratory allergy or infection, or both, and yet do not have asthma. Coughing is their only response to irritation. For this difference between individuals there is no satisfactory organic interpretation. An interpretation is offered, however, by the psychoanalytic theory of neurosis. Detailed psychoanalytic studies of asthmatics have led to the conclusion that the asthmatic attack is a sort of substitute for an inhibited or repressed cry of anxiety or rage. It is often a cry to gain affection from a denying and rejecting mother. A person chooses the asthmatic pattern for the expression of his emotional conflict, probably either because of a constitutional determinant or because of conditioning by one or more episodes of organic bronchial obstruction.

The obstruction which produces the wheezing dyspnea in bronchial asthma is caused by three factors acting singly or in common. These are bronchospasm, plugging by mucous secretion and edema of the bronchial mucosa. At the beginning of the attack bronchospasm appears to play the most important obstructing role. As the attack progresses mucous plugs and bronchial edema assume the more important obstructing roles.

As obstruction sets in a series of related physiologic disturbances develop. These are progressive and self-propagating and result in a vicious spiral which may end in death. The first of these disturb-

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ances is the development of a marked increase in negative intrapleural pressure during inspiration. This creates a sucking action on the capillaries of the bronchi, causing the development of bronchial edema. Meanwhile pulmonary emphysema develops with flattening of the diaphragm, diminution in vital capacity and increase of residual air. These interfere with the respiratory exchange and add to the anoxemia. Anoxemia produces anoxia, particularly of the medullary respiratory center. The patient then becomes dyspneic. His respiration is labored. As a result he is concerned only with getting his breath and fears to take time out to drink. At the same time the labor of breathing causes a profuse outpouring of sweat. Furthermore, the drugs taken for relief are often diuretic. These three factors—water deprivation, excessive sweating and diuresis—cause hemoconcentration. Hemoconcentration not only adds to the anoxia, it also causes the mucous secretion in the bronchi to become thick and viscid, further increasing bronchial obstruction.

Simultaneously with the development of anoxemia and anoxia there is an excessive accumulation of carbon dioxide. In consequence the oxygen dissociation curve is changed so that tissue anoxia is further increased. The excessive accumulation of carbon dioxide, the lack of oxygen and the effect of depressant drugs may make the medullary respiratory center completely inactive. Respiration is then carried on only by anoxic stimulation of the carotid body and aortic chemoreceptor centers. When these become depressed, death from respiratory failure results.

RESPONSE TO EPINEPHRINE

This rather brief summary of the pathological physiology of bronchial asthma clarifies several diagnostic and therapeutic observations concerning the development and course of an asthmatic attack. For example, we know that many patients when seen early in an attack of asthma or in a mild attack respond almost miraculously to an injection of 1/1000 epinephrine. On repeating the injection its action may become more and more transitory and ineffective. The patient has become epinephrine-fast. Many explanations have been given for the development of this state—among others, that a tolerance to epinephrine has been established; i.e., that bronchospasm is no longer relieved by epinephrine. Since this is contrary to what has been found in the experimental laboratory the only logical conclusion that can be drawn is that the patient has passed the stage where his bronchial obstruction is primarily due to bronchospasm and has reached the stage of bronchial obstruction due to mucous plugging and bronchial edema. Further administration of epinephrine at this stage is not only futile but even harmful. The observation that after a period of withdrawal epinephrine may again become effective does not mean that epinephrine reactivity has been regained but that the bronchial obstruction is again due chiefly to bronchospasm.

With the development of epinephrine-fastness we may conclude that the bronchial obstruction is due chiefly to mucous plugging or bronchial edema. Treatment must then be directed toward the relief of one or the other of these conditions. If the mucous that is coughed up is seen to be thick and tenacious and if in addition we find evidences of hemoconcentration, such as a high red cell count and high hemoglobin value, we may conclude that mucous plugging is probably the chief cause of the bronchial obstruction. Treatment is then directed toward the relief of hemoconcentration. This may be accomplished by the administration, by intravenous drip, of 5 per cent glucose in normal saline, which should be repeated or continued until such time as the red cell count and hemoglobin concentration have reached normal values. Glucose is used to combat the acidosis which accompanies any prolonged attack of asthma and normal saline is used to make up the electrolyte lost by the excessive perspiration and diuresis. To aid further in thinning down of the bronchial mucous, sodium iodide may be added to the intravenous drip.

IMPROVEMENT WITH RELIEF OF HEMOCONCENTRATION

As hemoconcentration is relieved the patient begins to cough up more and more plugs of mucous and generally within 48 hours has recovered from his acute attack. Meanwhile for immediate relief during episodes of acute exacerbations of dyspnea, 0.5 gm. of aminophylline may be administered intravenously or per rectum. Despite some evidence that aminophylline acts as a broncho dilator, its efficiency seems to lie chiefly in relieving fatigue of the medullary respiratory center, for many patients feel relieved after the administration of aminophylline yet show little if any change in the respiratory tracings taken before and after such administration. At this point it is also well to warn that aminophylline may act more as a diuretic than as a central stimulant. On occasion it has been known to cause such great diuresis that despite the administration of as much as five liters of intravenous fluids the hemoconcentration has not been relieved. Therefore, the blood must be frequently examined to determine the state of hemoconcentration.

Occasionally, despite disappearance of hemoconcentration the patient is not relieved and may not cough up any thick mucous plugs, in fact may cough up large amounts of thin, frothy sputum. We may then presume and perhaps confirm by bronchoscopic examination that the cause of the bronchial obstruction is bronchial edema. Under these circumstances the administration of 50 per cent glucose intravenously is indicated and often gives prompt relief.

RESPIRATORY DEPRESSANT DRUGS

A fundamental understanding of the mechanism of bronchial asthma is useful not only for preventive, curative and palliative treatment but also for avoiding improper treatment, treatment detrimental to the welfare of the patient.

The most serious menace to the welfare of the asthmatic patient is the depression of his respira-

tory center. With the development of anoxia the center becomes increasingly vulnerable to respiratory depressant drugs.

It is common practice to give such drugs to patients in an asthmatic attack. This is often necessary and justifiable if they are intended to relieve the asthmatic attack. The distinction is made on the basis of the dosage required for the relief of each condition. It takes a larger dose of a respiratory depressant drug or a more powerful drug to relieve an attack of asthma than it does to relieve fatigue or nervousness. With the respiratory center already depressed by a lack of oxygen and without any means of measuring the degree of depression, it becomes unsafe to attempt to relieve the asthma by this means. The powerful respiratory depressants such as the opium derivatives should never be used and the less powerful depressants such as the barbiturates should be used with infinite caution and only in small dosages. The anesthetics have no place in the treatment of the asthmatic attack, since they depress the respiratory center and, if used in effective dosage, inhibit the cough reflex which is so essential to the clearing of the bronchi.

In spite of all these strictures against respiratory depressants in the treatment of the asthmatic attack, many will cite experiences of their successful use. To this there is but one answer, that the drugs were given at a time when regardless of dosage or the type of drug used the respiratory center was not sufficiently depressed to be adversely affected. It is probably true that in many cases such treatment can be safely given but since we cannot always identify the patient or attack in which it is safe to administer a respiratory depressant and since measures which do not use respiratory depressants are effective, it would seem the better part of caution to avoid their use. Death in bronchial asthma should occur only from complications. It should never occur from the administration of drugs which are intended to prevent it.

Few asthmatics die without the aid of a doctor. The patient's panic often engulfs the doctor. He is then willing to try anything instead of using forbearance and caution and a continuous observation of the individual and his attack.

SUMMARY AND CONCLUSIONS

1. Bronchial asthma means bronchial obstruction regardless of the cause.

2. Bronchial obstruction calls forth a defense response, the abnormal respiratory pattern known as bronchial asthma.

3. The most common stimulants calling forth this defense mechanism are allergy and infection.

4. The bronchial obstruction produced by the defense mechanism is due to bronchospasm, mucous plugging and bronchial edema.

5. These lead to anoxemia, anoxia, dehydration and respiratory depression.

6. A proper appreciation of the physiological pathology underlying each of these conditions is the only basis for proper therapy of bronchial asthma.

123 N. San Vicente Boulevard, Beverly Hills, California.

MEDICAL PROGRESS:

Management of Patients With Various Types of Goiter

MAYO H. SOLEY,* M.D., *San Francisco*

MEANS[22] has stated aptly that "Forms of therapy ultimately survive or disappear in accordance with the impression they make on dispassionate, yet qualified observers." In a field such as that represented by thyroid diseases, one cannot hope easily to satisfy all practitioners of medicine. The surgeon traditionally thinks of goiter as a pass to the operating room, the internist tends to protect the goiter from the surgeon, the general practitioner tends to protect the patient. This paper is an attempt to correlate some of the recent advances in our knowledge of goiter to the end that appraisal of the individual patient and institution of therapy may be simplified.

ENDEMIC (NONTOXIC DIFFUSE) GOITER

In spite of Greenwald's[10] recent skepticism as to the role of iodine deficiency in the etiology of endemic goiter, small amounts of iodine remain the best treatment of this condition when there is no evidence of hypothyroidism. The adolescent who presents herself with a diffuse, non-nodular thyroid enlargement should be advised to continue a small (one drop of compound solution of iodine per week) dose of iodine indefinitely. Otherwise further enlargement may occur during pregnancies and the menopause with greater likelihood of the formation of involutionary nodules that in turn may go through degenerative changes necessitating subtotal ablation. Any decrease in size may take many months and by that time the patient may tire of taking or forget the need of iodine. Some system of follow-up should be adopted by the physician to be certain the patient continues treatment. Some of these patients have a low basal metabolic rate or one that is at the lower limits of normal with an elevated or high normal plasma cholesterol with clinical manifestations of mild hypothyroidism. Not infrequently iodine alone will suffice to relieve the mild hypothyroidism as well as to cause a decrease in the size of the goiter. When the rare complication of frank hypothyroidism occurs, substitution therapy with thyroid is indicated.

NONTOXIC NODULAR GOITER (SINGLE NODULES)

In 1938, Schlesinger, Gargill, and Saxe[28] reviewed the protocols of 1,371 autopsies in which the thyroid had been examined. They concluded that under the age of 30, a palpable nodule in the thyroid should be considered potentially malignant, that this malignant potentiality becomes greater between the ages of 30 and 50 (although a larger proportion of such nodules will prove to be benign) but that after 50 nodules in the thyroid are so frequent as "to be almost physiologic." In 1945, Cole, Slaughter, and Rossiter[5] and later Hinton and Lord[16] again pointed out the dangers of malignancy in nodular goiters; the latter authors suggested that a nodule in the thyroid has the same significance as a lump in the breast.

Table 1[17] shows the incidence of benign and malignant tumors to be so high in patients with solitary nodules in the thyroid that radical removal is the indicated treatment.[40] The presence of a single nodule, the simultaneous appearance of the nodule and pressure symptoms, the absence of a history of residence in an endemic goiter region or of other goiters in the family and a history of growth not associated with sudden enlargement, such as would accompany hemorrhage into a nodule, are all features that lead one to suspect that the nodule is a neoplasm. However, since no clinician is able to make a histologic diagnosis by palpation of a nodule through the superficial structures of the neck, the solitary nodule in itself dictates the need for radical resection. Previous workers have stressed the firmness of a nodule as favoring neoplasm but many thyroid tumors are no firmer than involutionary nodules. In fact, some of the papillary tumors are cystic and soft. In order to protect the 15 per cent of patients with early carcinomas and the 41 per cent with potentially malignment tumors, one has to advise thyroidectomy in all patients with single nodules. In patients with only involutionary nodules, this operative procedure relieves the pressure symptoms that often exist.

TABLE 1.—*Pathologic Diagnosis of Solitary Nodules in 97 Patients*

Involutionary nodules	35
Cyst	2
Thyroiditis	3
Unclassified	3
Adenoma	39
Intracystic papilloma	1
Malignant adenoma	1
Adenoma with invasion	2
Carcinoma	11
Total	97

NONTOXIC NODULAR GOITER (MULTINODULAR GOITERS)

When patients with probable or definite malignancies of the thyroid are eliminated, most patients with multinodular goiter will fall into (1) a group in which the goiter is an incidental finding and

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(2) a group in which the goiter is the presenting complaint.

The first group of patients probably will give a history of residences in an endemic goiter region, a family history of goiter, a long history of goiter and no local symptoms of pressure nor systemic evidence of any thyroid disease. Examination will disclose a nodular enlargement of the thyroid with minimal or no evidence of pressure on the trachea or recurrent laryngeal nerves. Even then the patient should not be advised "to forget the goiter" but to have periodic examinations of his goiter and to report any change in size or any pressure symptoms. Such a regimen seems more logical than the idea of removal of all goiters as expressed by Cole, Slaughter, and Rossiter.[5]

The second group of patients with pressure symptoms is almost certainly to be relieved only by subtotal thyroidectomy. Enucleation of nodules is an antiquated procedure and has properly given way to subtotal ablation. Providing sufficient iodine is administered throughout life, a few (as little as 3 to 5 grams) grams of thyroid tissue left *in situ* at operation permit adequate hormone production to maintain the patient in normal thyroid balance. In this group, the incidence of postoperative hypothyroidism is low and in any case can be treated easily with a desiccated thyroid preparation. Parathyroid deficiency and recurrent laryngeal nerve injuries are infrequent in the hands of well-trained thyroid surgeons.

TUMORS OF THE THYROID

Since Ward[37] and Pemberton[26], among others, have pointed out the relatively favorable prognosis in malignancies of the thyroid, a major task in the study of goiter in patients is the differentiation of involutionary nodules from neoplastic nodules, particularly before the patient reaches surgery. If the surgeon believes he is dealing with a tumor, he is better prepared to carry out more radical surgery.

Neoplasm should be suspected when (1) the patient has never lived in an endemic goiter region, (2) there is no family history of goiter, (3) the thyroid enlargement appears simultaneously with symptoms of pressure, and (4) the goiter shows evidence of growth. Hemorrhage or cystic degeneration producing sudden enlargement of the thyroid may take place in neoplasms as well as in involutionary nodules. Regional or distant metastases usually clinch the diagnosis of malignant tumor, except in the occasional instance when such tumors as carcinoma of the kidney metastasize not only to bones, lungs, and lymph nodes in the cervical region but also to the thyroid—the latter tumor in general gives other evidence of its origin.

The treatment of choice when a malignant tumor of the thyroid is suspected is total thyroidectomy combined with a radical neck dissection if regional metastases are found on the side of the tumor. More rarely a bilateral neck dissection must be carried out. The writer and most of the members of the Thyroid Committee of the University of California Hospital feel that this should be followed by x-ray only in those late cases where enough tumor remains, because of inability to remove the growth surgically, to cause continued pressure symptoms. Otherwise, x-ray is reserved for the inoperable patient and the inoperable recurrence.

Hamilton, Soley, and Eichorn[11] were unable to demonstrate signifiant deposition of radioiodine in carcinoma of the thyroid (two cases) and Hamilton[12] later reported two further cases studied by this group with similar findings. It was hoped, of course, that tumors of the thyroid would take up radioiodine and that this agent would be useful therapeutically. In 1942, Keston and co-workers[18] and, two years later, Frantz and co-workers[9] demonstrated the first positive evidence that thyroid carcinoma (metastatic) could take up radioiodine. In 1946, Leiter and his group[21] and again Seidlin and co-workers[29] reported therapeutic trials with radioiodine in two patients with metastatic carcinoma from the thyroid. Both of these patients had the unusual status of hyperthyroidism with the excess hormone apparently originating in the carcinomatous tissue. In ten patients with carcinoma of the thyroid studied at the University of California[31] recently, the metastases in one took up enough iodine^{131} to suggest that large doses could be expected to have a radiation effect and the metastases in two others showed definite uptake. (In these two it is questionable whether the deposition of radioiodine could point to later therapeutic effectiveness.) Thus it is apparent that at least a small percentage of patients with carcinomas of the thyroid can be expected to respond to radiation therapy in the form of radioactive isotopes of iodine. The requirements of equipment and personnel suggest limited use of this method for some time to come. In the writer's judgment, radioiodine will be used as a substitute for ordinary roentgen therapy and not for surgery.

THYROIDITIS

During the past decade, an apparent increase in thyroiditis has been noted. Whether this is due to better recognition of the thyroiditides or to an absolute increase is uncertain. The classification in Table 2 is the most useful one from the diagnostic and therapeutic standpoints.

TABLE 2.—*Classification of Types of Thyroiditis*

1. Acute infectious, with or without suppuration. Organisms: Streptococcus, staphylococcus, miscellaneous.
2. Chronic infectious. Syphilis, tuberculosis, and other granulomata.
3. Subacute or chronic with inflammatory process in thyroid. a. Strauma lymphomatosa (Hashimoto's struma, lymphadenoid goiter). b. Riedel's struma. c. Unclassified.

Diagnosis of the acute infectious type of thyroiditis depends on a story of some infection, usually respiratory, followed by tenderness and pain in the region of the thyroid, fever, signs of inflammation in the neck, and often symptoms and signs of acute hyperthyroidism. The process in

the thyroid may go on to suppuration. Occasionally the same organism may be cultured from pharynx and from thyroid. Treatment is with sulfonamides and antibiotics, with drainage if necessary. This type of thyroiditis represents about 5 per cent of thyroiditis seen at the University of California and in consultation practice and therefore is relatively rare in occurrence.

Chronic infectious thyroiditis is also rare and is far more common in autopsy material than clinical practice. In one recent case seen at the University of California Clinic, in which the Wassermann was positive and a biopsy showed a granulomatous process in the thyroid and in an adjacent lymph node, antiluetic treatment was followed by remarkable regression of the thyroid, decrease in the size of regional lymph nodes and relief of local symptoms. It must be admitted that no spirochetes were seen in sections and therefore the exact diagnosis remains in doubt. Tuberculosis of the thyroid is diagnosed without demonstration of tubercle bacilli in the majority of cases, and the better diagnosis is therefore "granuloma of the thyroid of unknown etiology."

Most patients with thyroiditis fall in group 3 (Table 2). Struma lymphomatosa is the most frequent type. Symptomatology is variable. Symptoms begin with pain and tenderness in the thyroid, with local pressure, malaise, low grade fever, and not infrequently a history suggesting hyperthyroidism. The thyroid is firm or rubbery to palpation and is usually but not always tender. Physical findings and laboratory tests usually do not confirm the presence of hyperthyroidism. The natural history of this little understood syndrome has not been clearly defined and the etiology is unknown; therefore no dogmatic statements can be made regarding therapy. Roentgen therapy may quiet down the process. If constriction of the trachea and dysphagia occur from paratracheal and retracheal extension of the thyroid, thyroidectomy probably is preferable to splitting the isthmus. Treatment with radioiodine is not likely to replace roentgen therapy since these glands take up little iodine in fact much less than do normal thyroids.[11, 31] Some of these patients develop hypothyroidism, and desiccated thyroid then should be administered. It is possible that substitution therapy with thyroid in all patients would shorten the course and help prevent recurrences.

Riedel's struma is characterized by stony hard enlargement of the thyroid (which may occur in part or all of the gland), obstructive symptoms and often hypothyroidism or myxedema. De Courcy[6] believes the primary process to be due to arterial changes, a view that does not have wide acceptance. Joll[17] has emphasized the poor prognosis without thyroidectomy, death being caused generally by respiratory obstruction. There have been no deaths among the eight or so patients I have seen. The major complication of surgery has been recurrent laryngeal nerve injury, in one case requiring a King[19] procedure because of bilateral cord paralysis. All of my patients have needed thyroid postoperatively.

The third group of subacute or chronic thyroiditis (Table 2) represents the most frequent type seen at the University of California Clinic in recent years. The clinical picture is more fulminating than that seen in struma lymphomatosa and the pathological picture includes lymphocytic infiltration and scarring. Fever may reach 103 degrees Fahrenheit or higher, the thyroid is more tender and painful than in struma lymphomatosa, the sedimentation rate rapid and clinical and laboratory evidence of hyperthyroidism not infrequent. The course runs for six to eight weeks and may be followed by recurrent and equally severe relapses. The etiology is unknown. Treatment has been radical thyroidectomy and subsequent therapy with desiccated thyroid. King and Rosellini[20] first reported good results in eight of eleven patients with thiouracil treatment in a dose of 0.2 Gm. three times daily for about three weeks. The writer has had dramatic success with three patients, reasonable success with two, and apparent failure in two patients. This therapy is empirical but efficient enough to warrant thorough trial and study.

HYPERTHYROIDISM

Means[22] stated in 1946 that "with newer forms of therapy available, the whole question of what is the best form of treatment for Graves' disease is again thrown wide open" although in 1942[23] he had stated, "The conclusion seemed warranted that subtotal thyroidectomy following adequate preparation by a course of iodine offered more overall benefit than any other program then available."

Patients with hyperthyroidism and nodular goiter should be prepared with iodine or thiouracil (or propyl thiouracil) and iodine and then be subjected to subtotal thyroidectomy. The only reasons for not subscribing to this outline of therapy should be (1) refusal of the patient to submit to operation and (2) the coincidence of other diseases that make the risk unwarranted.

Patients with hyperthyroidism and a diffuse (non-nodular) goiter may be offered a wider range of effective therapeutic regimens. Preparation with iodine followed by subtotal thyroidectomy represents the best therapy in the average patient. In severe hyperthyroidism, especially with a greatly enlarged thyroid and with complicating ectopic cardiac rhythms and cardiac failure, thiouracil or propyl thiouracil plus iodine bring the patient more successfully to a euthyroid state and thereby diminishes the operative risk.*

Roentgen therapy in adequate dosage remains a good method of therapy in selected patients.[32] Selection is based on (1) a moderate degree of hyperthyroidism, (2) moderate enlargement of the thyroid (not over 50 to 60 grams), (3) absence of nodules in the thyroid, (4) absence of complicating cardiac problems, (5) preferably absence of sun sensitivity, and (6) absence of history of recur-

* Readers are referred to the excellent and comprehensive review by S. L. Gargill and M. F. Lesses in the New England Journal of Medicine, vol. 235, pp. 717-728, November 14, 1946, for some of the fundamental aspects of diseases of the thyroid gland with an extensive bibliography.

rent laryngitis. These simple criteria will allow the inclusion of a fair portion of all patients with hyperthyroidism and reasonable certainty of results satisfactory both to patients and physician.

Radioiodine[4,13,14,15] as a form of irradiation therapy for Graves' disease has now had a trial of five years. Actually, limitations in the amount of radioactive iodine available make our experience in terms of adequate follow-up somewhat scanty, although the volume of patients treated by the two groups at the Massachusetts General Hospital and the group at the University of California Hospital has provided sufficient experience to allow certain conclusions.

When adequate dosage of radioiodine is administered, the thyroid returns to normal size and clinical symptoms are relieved more rapidly than with x-ray. Single doses of even 2,000 microcuries may produce a temporary exacerbation of symptoms of hyperthyroidism and mild to moderate local tenderness in the thyroid. Methods of measurement of radioiodine have varied so that there has been some difference between the San Francisco and the Boston millicurie, the latter being smaller. Also the average physician will be confused by tremendous variation in the total recommended doses, a variation due in part to the type of iodine used (iodine^{130} with a half life of 12.6 hours and iodine^{131} with a half life of eight days), in part to differences in measurement of the dose, and finally to difference in judgment on the part of the therapist as to the amount needed. It is important to measure the uptake of iodine by the thyroid of each patient with each dose in order to estimate the total radiation of the thyroid. These technical details are mentioned in order to stress the point that radioiodine therapy is not yet one that can be given outside of certain centers. The writer is convinced, however, that radioiodine will soon be an accepted, satisfactory method of treating a larger proportion of patients with Graves' disease than would be chosen for roentgen therapy, and may even replace surgery for the average patient.

ANTITHYROID AGENTS

Antithyroid agents, represented mainly by thiouracil and propyl thiouracil, may be used to prepare patients for surgery[27] or alone as medical treatment[1,2,38,39] Two factors that warrant consideration are (1) 50 per cent of patients so treated will have recurrence of hyperthyroidism after thiouracil is discontinued, and (2) toxic reactions occur in about 15 per cent of all patients. The mortality from thiouracil alone is approximately 0.5 per cent and thus equals the surgical mortality found in most clinics.[25,36] Leucopenia occurs in just under 4 per cent and agranulocytosis in nearly 2 per cent. These brief data lead one to the conclusion that thiouracil itself will not long be used in the medical treatment of Graves' disease.

In contrast to thiouracil, propyl thiouracil[3] is just as effective and far less toxic. In a recent personal communication, Doctor Astwood stated that he had treated 180 patients with propyl thiouracil with no severe toxic reactions; indeed the only toxicity exhibited was mild drug fever in two of his patients. This derivative, then, offers far greater promise than thiouracil, and it and perhaps other derivatives, as yet undiscovered, will write a new chapter in the therapy of Graves' disease.

Means[22] in 1942 stated that "in certain cases long continued exhibition of iodine alone had been found to be sufficient treatment" in Graves' disease, and further in 1946 that "this last may still hold true occasionally." I feel that iodine alone is rarely indicated.

TREATMENT OF HYPERTHYROID PATIENT WITH SEVERE EXOPHTHALMOS

The hyperthyroid patient who has severe exophthalmos[7,8,24,33,34,35] presents a special problem. Treatment must be directed in a manner that will protect the eyes. Such a patient has two chances out of five of having a significant increase in exophthalmos if he is prepared and his thyroid is subtotally resected in the usual manner. If, following thyroidectomy, he is given thyroid to tolerance, he has somewhat less chance of further protrusion of his eyes. If only the eyes are treated and he is given iodine and thyroid to tolerance, one is faced with the difficulty of treating two diseases. While the eyes are being treated fairly, is his hyperthyroidism also being treated fairly? The answers to management of this special group of patients probably are that (1) the eyes should be treated with thyroid to tolerance, (2) the hyperthyroidism should be treated according to one of the methods outlined in preceding paragraphs.

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EDITORIALS

Aerosol Therapy

Respiratory diseases have been treated by inhalations since the very beginnings of the medical art. Fresh air, salt air, desert air, and medicated steam inhalations are all forms of therapy so common and long practiced that they are scarcely regarded as special forms of treatment. Of these, salt air and medicated steam inhalations are actually forms of aerosol therapy. During the era of heroic medications, patients were subjected to inhalation treatments with mercury in vaporatoriums. Absorption through the lungs was so efficient that the frequency of resulting mercury poisoning forced the abandonment of this procedure.

In recent years the successful use of concentrated epinephrine aerosol by inhalation for the relief of acute attacks of bronchial asthma has stimulated interest in the use of other aerosols for respiratory diseases in general.

Beginning with the work of Sales-Eirons in 1855[1] continuous investigation by a series of workers has been carried on to determine the local effects, the degree of systemic absorption, and the distribution in the air spaces of the sinuses and lungs of inhaled medications.

The extent of distribution of these substances is dependent on the velocity with which the aerosol is delivered and the strength of the suction created by the individual's inhalation. Once in the respiratory chambers the aerosol will be further distributed by diffusion and convection, as well as by the action of the cilia.

The size and weight of the particles which constitute an aerosol suitable for inhalation have been determined. The spray produced by an ordinary atomizer is unsatisfactory because it is composed for the most part of droplets too large and heavy to be inhaled into the tortuous air passages and chambers of the respiratory tract. In practice, the suitability of an apparatus can be quickly tested by directing the mist it generates against a glass surface, which must remain clear of drops if it is to be satisfactory.

There are several sources of pressure for operating the nebulizing apparatus. A rubber bulb squeezed by hand or foot, a tank of compressed air, oxygen, helium, or carbogen or even steam can be used. Each has its conveniences and special advantages.

The most common medicinal aerosol in use at the present time is epinephrine. The idea of its administration by inhalation appeared very soon after the effectiveness of it by hypodermic injection was demonstrated.[2] This practice was abandoned because the 1:1000 epinephrine employed at that time for inhalation did not relieve the ordinary attack of bronchial asthma. It was not until about 1933 that the idea of using a more concentrated solution occurred. The method was reintroduced because of the simplicity of technique, the rapidity of action, the relative freedom from constitutional side effects, and the dramatic relief secured. A 1:100 solution of epinephrine is now in general use.

During the war much was learned about the effects of inhaled materials which is now being applied for therapy. The chemical warfare service was charged with the responsibility of developing and studying noxious and lethal aerosols, and at the same time their possible counter measures. Dr. Harold Abramson was placed in charge of the medical aspects of this investigation. He had at his disposal the facilities of the commercial nebulizer manufacturer and their research departments, laboratories for animal experimentation together with a sufficient number of trained experts and personnel to work out the many phases of the problem.[3,4]

Professor A. L. Krueger in studying influenza used his authority and facilities as head of the Navy Medical Research Unit No. 1 to investigate

the transmission of "air-borne" infection in general. He demonstrated the uniform distribution of inhaled aerosols throughout both lung fields of the experimental monkey, using as an indicator radioactive chromic phosphate.[5]

For many years patients have attributed certain attacks of bronchial asthma to the aftermath of an upper respiratory tract infection even though the classical signs and symptoms; muscular aches and pains, fever, and leukocytosis were not always present. Allergists on the other hand would write long and learned sounding articles with long bibliographies insisting that infection was not the precipitating cause, but that what the patient thought was an infection was simply the beginning of an asthmatic attack. It appears that the patient may be right, for if penicillin, streptomycin, tyrothrycin, hydrogen peroxide or sulfa solutions are prescribed for use in his nebulizer, he can often secure relief, and abort the usual prolonged siege. This phenomenon merits further consideration.

Now that the use of inhaled medicaments has been re-established as a potent therapeutic procedure, more detailed studies exploring the wide selection of agents suitable to be nebulized are indicated. One technique for the selection of the best aerosol to be used for a particular patient is to actually drop the solution on the colonies that grow on the patient's sneeze or cough plate, and see which solution is most lethal to the colonies present.

Investigations are under way for applying the principles of aerosol therapy to most of the diseases of the upper and lower respiratory tract. To date, the complicating secondary infections incident to bronchitis, bronchiectasis, and pulmonary tuberculosis are being treated by this technique. Patients subjected to chest surgery are treated pre-operatively and postoperatively to lessen their sputum, thereby relieving a great deal of their cough and expectoration.

Obviously the doctor must control the administration of solutions prescribed, as hypersensitiveness and acute reactions are to be expected in the use of drugs by inhalation, just as they are encountered coincident to the use of them by mouth, locally on the skin or by parenteral administration.

A new chapter in drug administration by aerosol therapy is being written. The simplicity of application should not minimize the physicians responsibility to its intelligent use.

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Health Insurance Propaganda

Governor Warren's announcement of last December concerning the reintroduction of his compulsory health insurance scheme has now borne fruit and Senate Bill 788 and Assembly Bill 1500, companion measures, are formally before the Legislature. With their introduction there has again been unleashed the propaganda technique which became so familiar two years ago on the 1945 version of this plan.

The words "propaganda technique" are used advisedly, principally for the reason that the truly unbiased observers of health insurance plans admit that they are groping in the dark in assaying such measures. The body of information available is still incomplete; its content suggests so many variations of practice and philosophy that a discussion becomes extremist on both sides.

On his side the Governor has available the power of his official office, an office which gives him constant contact with the press on a basis where the very prestige of his position lends weight to his words. On the side of the physicians, the only public information avenue open is through professional public relations consultants. It is obvious that both sides have already used and will continue to use the methods at their disposal.

On a broad basis the Governor's appeal is directly to the people, with pathos, human interest, emotionalism and big-hearted government as the keys used to unlock hearts and votes. The doctors can use nothing but cold logic, scientific knowledge and practical experience in presenting the opposition. The doctors start out behind scratch for the simple reason that it is difficult to tell people that they cannot have something which someone else is offering in attractive dress. Who can find the man who doesn't want to accept something for nothing?

With this situation in existence, the words of a recent speaker before a group of California physicians take on a particular significance. In effect this speaker told his listeners: "The proponents of compulsory health insurance are having a field day telling people what is going to be given to them; it is about time you doctors told the people what would be taken away from them under such a scheme."

The people most certainly have the right to know what price they must pay for a social measure held out as benefiting them. Perhaps they want to decide for themselves whether or not the service is worth the cost. For instance, do the people want compulsory health insurance if it means they will lose the services of the doctors of their own selection? Do they want socialization in the distribution of medical service, with the attendant red tape

and form-filling-out that goes along with governmentalization of anything? Do they want to pay their health care dollars to a horde of bureaucrats instead of their own doctors?

Do the people want to have their own doctors taken away from them? Do they want to have their own freedom of movement, their own independence of action in seeking medical care taken away? Do they want to have taken away the limitless services which they may now seek, in favor of an OPA approach of scarcity? Above all, do they want to have taken away the high quality of medical skill which is now available to them?

These are some of the questions which the people of California will want to answer to their own satisfaction before they embrace a glittering generality in the form of a compulsory health insurance scheme. These are some of the questions to which they have the right to demand answers from those responsible for drafting and introducing this legislation.

The California Medical Association has assumed the role of leader of the forces opposing Governor Warren's bills. There are many other opponents, in fact an increasing number, but it falls to the lot of the organized physicians to spearhead the attack. In this connection the C.M.A. can promise to the people of California that the answers to these and many more questions will be supplied. After that it is up to the people to decide the case on its own merits. The C.M.A. does not fear that decision.

76th Annual Session
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Los Angeles
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For hotel reservations, write Convention Department, Los Angeles Chamber of Commerce, 1151 South Broadway, Los Angeles, Calif.

Clinical-Pathological Conference*

Case History: V. H., a white female, aged 83 years, entered the hospital with the complaint of having had a sudden onset of severe abdominal pain two days previously, associated with nausea and vomiting. The patient, not being mentally clear, could not further describe the character of the pain. She was given laxatives and prostigmine by a physician at home without relief of pain or production of bowel movement except for passage of a small amount of gas after the prostigmine. The patient stated that she had had similar episodes in the past three or four years but that the severity was not as great and relief was obtained with cathartics.

Physical Examination: On admission to hospital, temperature was 98.8°, pulse 90, respiration 20, blood pressure 148/80. The patient appeared acutely ill and in severe pain. She was semi-comatose. Vomiting was frequent. Other positive physical findings included bilateral cataracts, advanced arteriosclerotic changes in fundi, slight cardiac enlargement, morbid sclerosis of the peripheral arteries and occasional fine moist rales at each lung base. The abdomen was moderately distended but not rigid, there was generalized tenderness but peristalsis was absent, and no organs or masses were palpable.

Laboratory Examinations: The Hemoglobin was 17.5 grams, erythrocytes numbered 5.05 million, WBC numbered 12,900, with 80 per cent neutrophiles (25 per cent of which were non-filamented), 17 per cent lymphocytes, and 3 per cent monocytes. Urinalysis revealed albumin 2 plus, 30 to 40 white blood cells per high power field, occasional red blood cells and no casts. The blood amylase value was 580 units and that for urinary diastase was 8 units. Roentgenogram of the abdomen in the upright position showed definite evidence of dilated loops of small bowel occupying the lower half of the abdominal cavity. Several fluid levels were seen in the small bowel. Very little gas was noted in the colon.

Clinical Course: Intravenous fluids, mild sedation and a blood transfusion were administered, and a Miller-Abbott tube was passed. On the first day after admission, the abdomen was fairly flat and less tender. Foul smelling, bile stained fluid was drained from the tube. The patient occasionally vomited 30 to 90 cc. of similar fluid. Occasional peristalsis was heard. The urinary diastase was 64 units. The temperature fluctuated between 96.6° and 100.2°. On the second day the patient clinically improved. The abdomen was soft and not tender. Small amounts of gas were passed by rectum. The temperature varied from 99.6° to 100.8°. On the third day the abdomen was flat, soft and not tender. Occasional peristaltic sounds were heard. The tube was removed but had to be re-inserted because of nausea and vomiting. The NPN was 60 mg. per cent, plasma chlorides 277 mg. per cent, creatinine 2.2 mg. per cent, WBC numbered 6,850 per ccm. (80 per cent neutrophiles, of which 33 per cent were non-filamented). The temperature was from 99° to 100°. The abdomen remained soft and flat but the patient continued to appear exhausted. The amylase values returned to normal but blood nitrogen levels remained elevated. A small brown stool was passed.

Subsequently the patient failed to improve, despite continued suction. The abdomen remained soft and non-tender. Intravenous fluids and transfusions were given. Death occurred on the eleventh hospital day.

* From St. Vincent's Hospital, Los Angeles.

CLINICAL DISCUSSION

DR. LOUIS C. BENNETT: In this differential diagnosis one must consider the more serious conditions commonly encountered in the practice of geriatrics. From the limited information available this would include pneumonia, coronary thrombosis, intra-abdominal vascular accident, intra-abdominal malignancy, acute appendicitis, acute pancreatitis and diverticulosis with a superimposed diverticulitis and the complications therefrom. The final diagnosis must include: (1) The cause of the patient's illness, and (2) The cause of the patient's death.

Coronary thrombosis must be considered because of the patient's age, the arteriosclerosis noted in the fundi and the peripheral vessels, the suddenness of the onset and the associated severe prostration. It is generally known that the pain of coronary thrombosis may be predominantly abdominal. The abdominal distention and absence of peristalsis could have been manifestations of an associated adynamic ileus. The leukocytosis and low grade fever are in keeping with coronary thrombosis. However, the systolic blood pressure upon admission was 148 mm. of mercury and the diastolic pressure was 80 mm. of mercury. Although we have no record of the blood pressure during health, these figures do not represent any serious degree of circulatory collapse. With no actual evidence of circulatory collapse upon or subsequent to admission, it seems unlikely that the illness could have been due to a fatal coronary thrombosis.

Pneumonia, referred to by Osler as "the friend of the aged because they are taken off by it in an acute, short, not often painful illness," could have been responsible for this death. It is not uncommon that the early predominant symptom of pneumonia is abdominal pain. Nausea and vomiting are common in pneumonia, as is severe prostration and irrationality. Again the abdominal distention, the absence of peristalsis and the x-ray finding of distended small bowel might represent a secondary adynamic ileus. The degree of leukocytosis with the elevation in the non-filamented neutrophiles could very well be the blood picture of an overwhelming pneumonic infection in a patient with low resistance to that infection, and the urinary findings could be secondary to the toxemia of pneumonia.

Against the diagnosis of pneumonia of sufficient extent to explain the patient's initial illness is the respiratory rate of 20 per minute and the fact that the lungs were found clear, except for an occasional moist rale at each base which one might expect in an individual of this age who had been in bed for two days. Also against pneumonia is the fact that the abdominal symptoms persisted throughout the illness, and that no mention is made of dyspnoea or cyanosis. From the information at hand it seems very improbable that pneumonia could have been the primary illness, although a secondary bronchopneumonia must, of course, be seriously considered as a contributing cause of death.

Under vascular accidents one must consider mesenteric thrombosis and dissection or rupture of or aneurism of the abdominal aorta.

A diagnosis of mesenteric thrombosis seems possible because of the suddenness and severity of the attack in an elderly arteriosclerotic individual. The history of previous similar episodes could be explained by progressive sclerosis of the superior mesenteric artery, with the fact that the episodes were relieved by cathartics left unexplained by this theory. The laboratory findings, including the elevation of the blood amylase and urinary diastase, could all have been secondary to such a vascular accident. The x-ray findings might be considered in keeping with this diagnosis. The progressive downward course and fatal outcome could be explained by an overwhelming peritonitis secondary to mesenteric thrombosis. However, the absence of peristalsis upon admission and the absence of blood in the stools leave two of the most constant findings in mesenteric thrombosis lacking. These, plus the fact that the patient lived for eleven days, seem to rule out mesenteric thrombosis as the cause of the patient's illness.

Abdominal aneurism with dissection or perforation must be mentioned under vascular accidents, although there is little to support the diagnosis. Aneurism is commonly found in the third to the fifth decade and is usually fatal before the age of this patient is reached. It is a condition much more common in males than in females. An important symptom of dissecting aneurism is pain, and upon perforation it is rapidly fatal. In the absence of a palpable tumor and with no evidence of intra-abdominal hemorrhage, the diagnosis of abdominal aneurism is dismissed.

Intra-abdominal malignancy must always be considered in a patient of this age. Malignancy of the colon with sudden onset of obstruction or perforation might explain the onset of the illness, and could give this clinical and laboratory picture. However, the history of similar episodes for the past three or four years is not in keeping with the usual history of malignancy of the colon. From the daily observations of the patient's course in the hospital one does not get the impression that she had an obstruction of the colon. There was certainly insufficient evidence of intestinal obstruction to cause one to suspect the complication of generalized peritonitis on the basis of prolonged unrelieved distention of the bowel. An uncomplicated organic obstruction of the colon on the basis of malignancy would explain neither the severe prostration at the onset nor the patient's clinical course. She was relieved some by the Miller-Abbott tube in 24 hours. She passed "gas" on the second hospital day and a "small brown stool" on the fifth day. This is not in keeping with obstruction of the colon of sufficient severity to explain this illness. Malignancy of the pancreas must be mentioned, but the sudden onset, the rapid course and the absence of jaundice seem to rule it out.

Acute appendicitis with perforation and generalized peritonitis must be considered and since it was not possible to obtain a detailed history of the onset, character and localization of the pain, I do not believe this diagnosis can be completely eliminated. Although appendicitis in the aged is rare, it does occur even at 83 years of age. Recurrent acute appendicitis would explain the repeated previous similar episodes. Two days had elapsed between the onset of the abdominal pain and the admission to the hospital. The onset of the pain was accompanied with nausea and vomiting which are characteristic of acute appendicitis. With the lapse of 48 hours, plus the influence of the laxatives and the prostigmine, the complication of a generalized peritonitis secondary to gangrenous or perforated appendicitis could have been present upon admission, and would very well explain the entire illness up to that date; the picture being that of an overwhelming infection in which one would expect an early fatal termination. One would not expect the patient to live for 11 days after admission with such a picture. Chiefly on this basis it would seem unlikely that appendicitis and the resultant complications were the causes of the illness and death, although from the available information it is impossible completely to dismiss these diagnoses.

The diagnosis of acute pancreatitis is suggested, more by the laboratory findings than by the history and clinical findings. Pancreatitis may occur in any degree, and may subside and recur. This also would explain the previous attacks. The sudden onset of the attack might well have been the beginning of an acute fatal pancreatitis. A few years ago the elevated blood values of pancreatic enzymes would have been accepted as diagnostic of acute pancreatitis. However, it is now generally accepted that these values may be markedly affected in other serious intra-abdominal conditions, and that they are not diagnostic of diseases of the pancreas. Although the history lacks detail, no mention is made of any evidence of shock, or of the typical back radiation of the pain that is common in pancreatitis. These two symptoms are of great importance in the diagnosis and both are lacking. Fatal acute pancreatitis is usually more rapidly fatal than was this illness. Therefore, in spite of the pancreatic enzyme blood values, the diagnosis of acute pancreatitis seems improbable.

Diverticulosis of the intestinal tract. usually of the colon, is an affliction that is common in the aged. The typical course is one of recurrent exacerbations of acute diverticulitis superimposed upon the chronic process, with remissions that may leave

the patient symptom-free for variable periods. The serious complications that occur during the acute exacerbations are mechanical obstruction, either in the colon or in loops of adjacent small intestine that become involved in the inflammatory process, or both, and perforation with localized abscess or generalized peritonitis with secondary adynamic ileus. During an acute attack it is frequently difficult to distinguish between these complications. The differentiation is best made by following the patient's clinical course closely from the beginning of the attack with frequently recorded auscultatory examinations of the abdomen. Although the first recorded examination of this patient was made two days after the onset of the attack, the diagnosis of chronic diverticulosis complicated by acute diverticulitis with perforation, peritonitis and associated ileus would best explain her illness. The patient was certainly in the "diverticulosis age." This diagnosis explains the previous similar attacks.

That these attacks were relieved by cathartics is probably best explained by the fact that many patients still empirically take cathartics for abdominal pain, plus the good fortune that no perforation occurred during the attacks. Some degree of peritonitis, possibly with some attempt at walling off, would explain her physical findings and her critical condition upon admission. The pancreas may or may not have been involved in the inflammatory process. The ileus would explain the distention, the x-ray findings and the apparent relief by intestinal intubation decompression. That there was some subsidence of the ileus is manifested by the "occasional peristalsis heard" on the first and third hospital days and by the passing of gas per rectum. However, three days of decompression is insufficient management in severe adynamic ileus, therefore the recurrent nausea and vomiting and the necessity for reinsertion of the Miller-Abbott tube. From the daily recorded examinations of the abdomen there was decreasing evidence of peritonitis, but the patient did not improve. This might mean decreasing resistance to the infection, or some additional complicating factor. Upon admission the urine contained two plus albumin, 30 to 40 white blood cells per high power field and occasional red blood cells. On the third day the non-protein-nitrogen was elevated to 60 mgm. per 100 cubic centimeters of blood and the creatinine was two and two-tenths mgm. per 100 cubic centimeters of blood. The note on the fifth day states, "nitrogen levels elevated." The total daily volume output of urine and the microscopic findings of the urine would be of considerable interest at this point. However, there is sufficient laboratory evidence of azotemia to indicate that the patient was developing progressive renal failure; the mechanism being, no doubt, that of an acute toxic nephritis, or nephrosis, superimposed upon old arteriosclerotic kidneys. In addition to this, one would almost certainly predict terminal bronchopneumonia in this patient.

Clinical Summary: 1. Chronic diverticulosis, probably of the colon, with acute diverticulitis and perforation. Contributing causes of death were: 2. Generalized peritonitis; 3. Acute toxic nephritis, or nephrosis, superimposed upon the old arteriosclerotic kidneys and, 4. Terminal bronchopneumonia.

PATHOLOGIST'S DISCUSSION

DR. J. E. KAHLER: In spite of the patient's soft, flat, non-tender abdomen, gas escaped when the peritoneum was incised, and the abdominal cavity contained about 500 cc. of thick brown exudate having a foul fecal odor. At a point 110 cm. above the ileocecal valve, the ileum was tightly incarcerated in a femoral hernial sac which lay beneath Poupart's ligament and approximately 4 cm. lateral to the symphasis. The sac itself was only 2 cm. in depth and had a very narrow orifice so that it could be everted only when Poupart's ligament was trans-sected. The bowel at the point of incarceration had the definite "T" shape of a Meckel's diverticulum, the base of the "T" representing the mesenteric portion with a functional, though small, lumen remaining outside the hernial sac. Just within the orifice of the sac, on the proximal edge of the diverticulum, there was a small perforation the edges of which were everted, red and granular as though having existed for some time. There was purplish discoloration of the bowel wall around this point. The mucosa of the diverticulum was smooth, viable and contained no ectopic elements. The tip of the diverticulum could not be separated from the point of the sac by blunt dissection, suggesting that the incarceration had been present for a long time and that this same hernia had caused the previous episodes of abdominal pain.

Doctor Bennett is to be congratulated upon his analysis of the case. His final diagnosis is incorrect only in the position of the diverticulum. It is noteworthy that he was not misled into diagnosis of acute pancreatitis by the high blood and urine amylase values. Small bowel obstruction is only one of many conditions within the abdomen which can product a high amylase without a lesion of the pancreas or other salivary glands. This patient's pancreas was normal both grossly and microscopically. The small bowel was considerably dilated above the diverticulum. Bronchopneumonia was not present. The kidneys were of the arteriosclerotic type with superimposed acute degenerative changes associated with the peritonitis.

Anatomical Diagnosis: Generalized peritonitis due to perforation of a Meckel's diverticulum incarcerated in a right femoral hernia.

CALIFORNIA MEDICAL ASSOCIATION

NOTICES AND REPORTS

NEWS *of the* DAY *in the* C.M.A.

February 5—Executive Committee meets in evening session, discusses problems of the day and sends members home at 11:30. A little more docket cleared up for coming Council meeting.

February 6-7—Various gatherings these days for Annual Session program. All indications point to excellent program and record attendance. Greatest shortage still in hotel rooms, which for some reason unknown to hotel men are still in tremendous demand. Office regretfully notifies many applicants that Biltmore Hotel has allotted C.M.A. only so many rooms and these are hardly enough to house officers, guest speakers, delegates, etc. Other hotels in Los Angeles cooperating nicely with Chamber of Commerce in housing C.M.A. members for session period.

February 9—Legislative meeting in Los Angeles. Plans laid for meeting Governor Warren's 1947 version of foot-in-the-door health insurance. Nobody yet able to figure out why the Governor stresses hospitalization and makes it easier for all people to get into hospitals when there is admitted shortage of hospital beds. Sounds like good politics rather than good medical care.

February 12—Covering two bases at once today. San Francisco Bay Area Councilors and officers of local society meet with Dr. Walter Judd, prominent member of Congress from Minnesota and outspoken Republican champion of free enterprise, particularly in distribution of medical care. In San Francisco for formal address at Lincoln Day dinner, Dr. Judd told medical group with all his accustomed vigor and style that medical profession must carry story to the people of what would be taken away from them in state or national compulsory health insurance plan. If we only had 434 more members like him in Congress!

In Los Angeles, legal counsel and medical representative meet with Social Security Committee of California State Chamber of Commerce. This committee two years ago took stand for voluntary and against compulsory health insurance and board of directors of State Chamber adopted that report. Comes now the 1947 chance on same issue and result remains the same. State Chamber of Commerce, by action of board of directors, approves voluntary and opposes compulsory.

February 13—Executive secretary off to New Mexico to confer with directors of New Mexico Physicians' Service re prepayment plan.

February 14-15—More stacks of bills coming in from Sacramento. State printer reported busiest man in county. Another 1500 bills yet to come. Complete file will make altitude of more than 36 inches; lots of reading here and lots of assorting, with estimated 10 per cent of bills containing some medical or public health aspect.

February 18—Back from New Mexico. Plan there progressing but faced with small potential and problem of meeting costs and continuing service for relatively small group that wants and needs service. C.M.A. has been behind New Mexico plan from outset and believes it necessary as one state's contribution to nationwide system of medically-sponsored prepayment policy.

February 19—Conference today with John Rooks, executive secretary of California State Dental Association and legislative representative of joint legislative committee of that organization and Southern California State Dental Association. Formerly secretary of the Alameda Chamber of Commerce, Rooks has entered into Sacramento situation with gusto and dental interests seem well in hand. This is good for physicians inasmuch as medical-dental interests are pretty much alike.

February 20—Copy prepared for first 1947 issue of "Legislative News." This publication will again be sent to all C.M.A. members during issue of compulsory health insurance. Members have found many helpful items in this leaflet in past and it is hoped new issues will be similarly beneficial.

February 22—Office closed today for Washington Birthday holiday. Weatherman obligingly furnishes delightful spring day. Office staff expected back Monday with usual assortment of sunburn, poison oak, horseback stiffness and other vacation ills. One student flyer hopefully expected back Monday.

February 24—No casualties. Three-day mail collection promises busy time for all, despite spring weather. Transportation problems besetting part of office; why is it so hard to get to Los Angeles and back on the *Lark?* Probably same question being asked today in 8,379 other offices in the city. If only we had a pneumatic tube service, operating both ways.

In Memoriam

BREUER, CHARLES HUGH. Died December 18, 1946, at San Jose, age 81. Graduate of Crieghton University School of Medicine, Omaha, Nebraska, 1896. Licensed in California in 1924. Doctor Breuer was a Retired Member of the Santa Clara County Medical Association, and the California Medical Association.

✤

DEARBORN, RAY RUSSELL. Died of a heart attack at Madera, December 29, 1946, age 58. Graduate of the University of Vermont College of Medicine, Burlington, 1911. Licensed in California in 1913. Doctor Dearborn was a member of the Fresno County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✤

ELLSWORTH, ALICE BARKER. Died January 7, 1947, at Long Beach, age 76. Graduate of the University of Michigan Medical School, Ann Arbor, 1902. Licensed in California in 1922. Doctor Ellsworth was a Retired Member of the Los Angeles County Medical Association, and the California Medical Association.

✤

FARMER, JOHN LEE. Died January 10, 1947, at San Diego, of cerebral vascular accident due to chronic hypertension and myocarditis, age 52. Graduate of Baylor Medical College, Dallas, Texas, 1918. Licensed in California in 1931. Doctor Farmer was a member of the San Diego County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✤

GOLDBERG, MILTON. Died at West Los Angeles, December 10, 1946, age 35. Graduate of the University of Minnesota Medical School, Minneapolis, 1936. Doctor Goldberg was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✤

JONES, ISAAC WILLIAM. Died December 23, 1946, at Los Angeles, of a heart attack, age 70. Graduate of Kentucky School of Medicine, Louisville, 1904. Licensed in California in 1912. Doctor Jones was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✤

MOCK, BYRON FAY. Died January 3, 1947, at San Diego, of coronary occlusion, age 47. Graduate of the University of Pennsylvania Medical School, Philadelphia, 1925. Licensed in California in 1930. Doctor Mock was a member of the San Diego County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✤

NITTLER, ADOLPH NICHOLAS. Died October 10, 1946, at Santa Cruz, of chronic rheumatic endocarditis and chronic parenchymatous nephritis, age 60. Graduate of the Oakland College of Medicine and Survery, 1909. Licensed in California in 1909. Doctor Nittler was a member of the Santa Cruz County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

PIUS, CHARLES. Died December 9, 1946, at Yreka, of coronary occlusion, age 63. Graduate of the Cooper Medical College, San Francisco, 1906. Licensed in California in 1906. Doctor Pius was a member of the Siskiyou County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✤

PRITCHARD, FRANK HIRAM. Died December 30, 1946, at Colton, of cerebral arteriosclerosis, age 79. Graduate of Boston University School of Medicine, Massachusetts, 1889. Licensed in California in 1903. Doctor Pritchard was a member of the San Bernardino County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✤

ROTHWELL, WILLIAM THOMAS. Died January 19, 1947, at Riverside, of coronary thrombosis, age 62. Graduate of the University of Illinois Medical School, Chicago, 1910. Licensed in California in 1910. Doctor Rothwell was a member of the Riverside County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

In appreciation of Dr. Harold Philips Hill

Doctor Harold P. Hill died on the last day of the year 1946. Few doctors will be so widely and so deeply mourned. Many persons in the San Francisco Bay region will feel shaken and unsteady at the loss of their trusted adviser and best friend, a pillar upon whom they could lean, a comforter to whom they could turn in time of trouble. Many persons, many families, scattered with the years over the four quarters of the globe will miss that quiet, patient, attentive man to whom they could pour out their complaints, their worries and their grief, and in whom they could find a wise and understanding counselor.

Doctor Hill, or "H.P.," as he was known to his friends, was born in Waterbury, Vermont, in 1877. His father was a doctor, who moved to California from Vermont in 1887, practiced and lived in Redlands, and died there in 1927. Doctor Hill was graduated from Stanford in 1898 and from the University of California Medical School in 1901. He was interne and afterwards resident at St. Luke's Hospital. There he was one of a tennis-playing quartet, which included Doctors William G. Moore, George McChesney and Sumner Hardy. From 1902 to 1906 he was instructor in Physiology at the University of California Medical School, practicing medicine at the same time. He left the University of California for Stanford during the days of Walter Hewlett, becoming Assistant Clinical Professor of Medicine in 1907. For years he was Chief of the Stanford Medical Service at the San Francisco Hospital, but retained a constant interest in St. Luke's. Chief of the Medical Service and Chief of Staff at St. Luke's for many years, he helped to set its high standards of nursing and medical practice.

He married a daughter of his old friend, Doctor Clark Burnham of Berkeley; he leaves her, their three children, and a brother and two sisters, Doctor Howard Hill and Miss Edith Hill of Redlands, and Mrs. F. R. Lanagan of Denver.

Doctor Hill united in rare adjustment all the gifts that go to make a good doctor: a most logical and direct mind, attentive to details but not distracted by them, which picked out essentials and weighed facts with uncommon perspicacity; a quiet and forebearing understanding, together with a silent receptiveness that made it easy for people to open their lives to him and trust him; an extraordinary memory for his patients' ailments, so reten-

tive and accurate that it often astonished the patients themselves; an absolute regard for truth and an unswerving unwillingness to compromise what he looked upon as right and just. It was good to see him at the sickbed; neither solemn nor loquacious or jocose, but quiet, steady, forthright, attentive and reassuring, with an occasional smile and a little laugh when he thought that one was in place.

His pleasures were few and simple, tennis and golf in his more active days, later a little fishing. His life was ascetically and undivertedly a doctor's; like an artist or a musician, he lived his profession during all his working hours. Where others might find pleasure or excitement in a successful shot at golf, or at a jolly party or in a political campaign, he cared for nothing but his profession and found his satisfaction in an abstruse diagnosis prettily solved or in a patient returned to him after long, fruitless wanderings elsewhere.

Many a sick person will stretch his arms out for you in vain, H.P., and wish that your tall, spare, big-boned figure, your green-blue eyes, your big forehead with its scanty hair, once sandy and wind-burned, your tight lips breaking into a smile of recognition and your reassuring, helpful hands might appear in the frame of the sickroom door and be again at his bedside. You were a good friend to me and mine, as you were to countless others. God bless you, faithful H.P. May you rest easy and the grass lie softly on your grave.

L. Eloesser.

(The above tribute to a distinguished physician was mailed to your Secretary from Nanking on January 15, 1947. The depths of friendship and appreciation are not often sounded in such manner. We think the world must know that many feel the qualities in H. P. H. that L. E. most admired are those with which he too is well endowed . . . and those whose fortune is to know such men, know history.—L.H.G.)

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NEWS and NOTES

NATIONAL • STATE • COUNTY

ALAMEDA

The staff of **Alta Bates Hospital,** Berkeley, has been reorganized following a recent change in management, with Dr. Grant Ellis as staff president, Dr. Woodburn K. Lamb as vice president and Dr. Arthur H. Rice as secretary-treasurer. In conformity with policy of the American College of Surgeons, the hospital is **to be departmentalized,** with general practitioners classified under services in which they are particularly skilled or under the heading of general practice.

CONTRA COSTA

Contra Costa County Medical Society and auxiliary members met recently at the home of **Dr. H. D. Neufeld** in Concord. At the meeting, **Dr. W. R. McCarthy** of Oakland, executive medical director of the Cancer Commission for the California Medical Association, discussed the advances made in treatment and study of the disease.

LOS ANGELES

Dr. Stafford L. Warren, who on February 1 began his duties as dean of the new medical school which is to be organized on the Los Angeles campus of the University of California, is at present assembling a faculty and staff and supervising plans for a new 500-bed university hospital and other buildings for the school.

Appointment of the new dean, formerly **professor of radiology** at the University of Rochester School of Medicine and Dentistry, and during the war chief of the medical division for the entire atomic bomb project, was announced last January by Robert Gordon Sproul, president of the University of California. He had been nominated for the post by Provost Clarence A. Dykstra of the Los Angeles campus and an all-university medical committee of which Dean Emeritus R. Langley Porter and Dean Francis S. Smyth of the university's medical school are members.

Dr. Warren, who was a member of the University of Rochester Medical School faculty for 21 years, will be **professor of biophysics** as well as dean of the new UCLA medical school. The school, to be designed for a student body of 300, is expected to be ready for its first students in 1948 or 1949.

In announcing the appointment, Dr. Sproul said: "Dr. Warren is eminently qualified for the task for which he has been chosen. He has made notable contributions to medicine in radiology and other fields, and his work on the atomic bomb project was of inestimable value to the nation. The fact that Dr. Warren also is a **graduate of the University of California** should be a source of pride and satisfaction to the people of the state."

Dr. Warren was graduated from the Berkeley campus of the University of California in 1918, and received his M.D. degree from the University of California Medical School at San Francisco in 1922. After graduation he served as assistant in pathology at the

DR. STAFFORD L. WARREN

Johns Hopkins Medical School, as medical interne in the Massachusetts General Hospital, and as resident physician in Huntington Memorial Hospital, Boston.

His present appointment marks the second time in his career that he has allied himself with a new medical school. He joined the University of Rochester School of Medicine and Dentistry as an assistant professor of medicine in 1926, one of the original group of men assembled by Dean George H. Whipple for the school, which accepted its first class of students that year. Dr. Warren rose to associate professor four years later, became full professor of radiology in 1939. He also has served as radiologist-in-chief at Strong Memorial Hospital, teaching hospital of the Rochester School of Medicine and Dentistry.

Given a leave of absence in 1943 to serve with the Manhattan District as a colonel in the U. S. Army, Dr. Warren directed the organization of the **atomic medical research** at the University of Rochester be-

fore taking over the task of directing the medical division for the nation's vast atom bomb project. He was a key figure at the first atomic bomb test in New Mexico, and later was sent on a mission to Nagasaki and Hiroshima to study the effects of the bombs dropped on Japan.

Last summer, as head of the radiological safety task force. Dr. Warren was the man primarily responsible for the safety of the 42,000 participants in the atom bomb tests at Bikini Atoll. Major General Leslie R. Groves, head of the Manhattan District, presented Dr. Warren the **Distinguished Service Medal** on November 3, 1945, for his outstanding part in the atomic bomb development. Dr. Warren's terminal leave from the U. S. Army ended on November 10, 1946.

His distinguished reputation is not based solely on his work for the atomic bomb project. He was well-known before the war for is work in radiology, was credited with pioneering a technique known as "fever treatment" for the cure of gonorrhea, and made important contributions to **cancer research.** He served for many years as special consultant to the U. S. Public Health Service.

Dr. Warren is a member of many **scientific and professional organizations** including Sigma Xi, Alpha Omega Alpha, Phi Chi, the American Neisserian Medical Society, the American Society for Cancer Research, the American Association for Clinical Investigation, and American Association for the Advancement of Science, the American Medical Association and others. He has written more than 100 scientific papers on medical subjects.

A native of Maxwell City, New Mexico, Dr. Warrent is a former resident of Hayward, California. At 50 years of age he is of impressive physical stature, standing six feet four. His wife is the former Viola Lockhart of Santa Rosa, California, who also attended the University of California and whom he married when he was a medical student in 1920. They have a daughter and two sons: Dean S., 19, now a pre-medical student at the University of Rochester; Roger W., 18, a sophomore at Rochester where he is majoring in physics, and Mrs. Jane (Fred C.) Uffleman, of Oak Ridge, Tennessee.

Dr. Tracy Comstock, recently discharged from the Army Medical Corps, is assisting Dr. Robert Reid in Perris while Dr. Reid convalesces from injuries received in an automobile accident. Dr. Comstock, who is a graduate of the College of Medical Evangelists, studied at both Loma Linda and White Memorial in Los Angeles.

Dr. Edson Hun Steele, recently returned from Naval service, has announced the reopening of his office at 305 South Westlake Avenue, Los Angeles.

Dr. William F. Reasner, veteran Santa Monica district health officer, retired from office at the end of February. He had been associated with the Los Angeles County Health Department since 1927.

Dr. Benjamin N. Anderson, recently discharged from military service, is once more associated with the Elmer Thompson Medical group, located at 146½ San Fernando Rd., **Burbank.** Since his release from service, Dr. Anderson has done post-graduate work at Iowa University Hospital and Cook County Graduate School of Medicine, Chicago.

Dr. William D. Mapes, who has recently been discharged from the Army Medical Corps, has become associated with **Dr. Paul Witten** in San Fernando. Dr. Mapes received his training at the University of Colorado Medical School.

Dr. Tracey Powell has been elected president of the **Hollywood Academy of Medicine** succeeding Dr. Nichol R. Smith. Dr. Charles Gilfillan has been named vice-president and Dr. Walter Scott, secretary-treasurer.

ORANGE

Dr. Arthur Trevenning Harris, Laguna Beach physician and surgeon who served as a captain in the Army Medical Corps during the war, has purchased property at 4635 Ledge Avenue, in **North Hollywood,** where he will engage in the general practice of medicine.

SAN FRANCISCO

Dr. Robert S. Stone, professor of radiology and chairman of the department of radiology in the University of California Medical School, has been elected an honorary fellow of the College of Physicians of Philadelphia.

Dr. Anthony J. J. Rourke, physician-superintendent and director of out-patient clinics, Stanford University Hospitals, and associate professor of hospital administration, has been appointed president of the **San Francisco Hospital Conference.**

Relatively low pay and unattractive working conditions are given by Dr. J. C. Geiger, San Francisco Director of Public Health, as the principal reasons for the **acute shortage of nurses** in the San Francisco Department of Public Health. In a report on the shortage, Dr. Geiger says that correspondence with nurses as well as his own investigations show that the pay rates are below those in health departments in other comparable communities for jobs considered to be the very hardest and most hazardous type of nursing. Moreover, pay for City-County employment is less than for more attractive work in private hospitals. In making comparisons of working conditions in the San Francisco Hospital with those in private hospitals, nurses among whom Dr. Geiger made a survey cited the **scarcity of labor-saving devices,** antiquated equipment, and lack of unskilled workers who could do much of the work which highly trained nurses are called upon to do.

Stanford University School of Medicine's 65th course of **Popular Medical Lectures,** which began March 7 will continue with Friday evening meetings through April 25. The schedule of lectures, with the names of speakers, follows: March 7, "New Eyes for Old: Corneal Transplants," Max Fine, M.D.; March 21, "The War on Cancer," David A. Wood, M.D., L. Henry Garland, M.D., Leonard G. Dobson, M.D.; April 11, "Delinquency and Mental Health in a Changing World," Hale F. Shirley, M.D.; April 25, "Contagion from Foreign Lands," Rodney R. Beard, M.D.

The University of California Medical School, under sponsorship of University Extension (Medical Extension), University of California, next fall will offer the following **postgraduate courses** to qualified practicing physicians: Postgraduate Course in Obstetrics and Gynecology, September 1 to 5, inclusive; Postgraduate Course in Otorhinolaryngology, September

8 to 12, inclusive; Postgraduate Course in Ophthalmology, September 15 to 19, inclusive. These are continuation courses for general practitioners of medicine. The subject matter will consist of clinical case demonstrations, discussions on the newer methods of diagnosis, and of medical and surgical treatment.

Requests for further information should be sent to **Stacy R. Mettier,** M.D., Head of Postgraduate Instruction, Medical Extension, University of California Medical Center, San Francisco 22, California.

TULARE

Dr. C. S. Ambrose, Visalia physician, who recently accepted the post of health officer of Tulare County, will give up his private practice. Dr. Ambrose succeeds **Dr. Charles C. Hedges.**

A 40-hour week for nurses and office personnel at the **Tulare County Hospital** has been approved by the County Board of Supervisors. Hiring of additional personnel, including five nurses' aides, also was approved.

YUBA

Dr. Paul C. Cress has been named to serve temporarily as county physician of Yuba County to fill the post which **Dr. William Vasques** resigned February 1 to resume private practice. Dr. Cress will serve on a month-to-month basis until a permanent appointment can be made.

GENERAL NEWS

The third annual convention of the **American Society for the Study of Sterility** will be held at the Hotel Strand, Atlantic City, New Jersey, on June 7 and 8, 1947, preceding the annual A.M.A. Convention. The general theme of the meetings will be that of attempting to disseminate to the physician treating marital infertility an overall picture of the latest advances in reproduction. The program will include original papers, round table discussions, scientific exhibits, and personal demonstrations. Registration for the sessions is open to members of the medical and allied professions.

Additional information may be obtained from the secretary, **Dr. John O. Haman,** 490 Post Street, San Francisco 2, California.

Dr. John Dunnington, professor of Ophthalmology at Columbia University, New York City, and **Dr. George Shambaugh,** professor of Otolaryngeology at Northwestern University, Chicago, will be guest speakers at the Eighth Annual Spring Post Graduate Course in Ophthalmology and Otolaryngology to be given in Portland, April 7-12, by the **Oregon Academy of Ophthalmology and Otolaryngology.** The program includes lectures, clinical demonstrations and ward rounds. Further information may be had from Dr. Harold M. U'Ren, Secretary, 1735 N. Wheeler Ave., Portland 12, Oregon.

The Third American **Congress of Obstetrics and Gynecology** will be held September 8-12, 1947, in St. Louis. Program of the Congress is designed not only for specialists but for general practitioners, nurses and all those interested in care of mothers and new born babies. It is being arranged by Dr. A. W. Diddle of Dallas as general program secretary. Program sub-sections are being developed by section chairmen. Dr. Ralph A. Reis of Chicago heads the Medical sub-section and is assisted by Dr. John I. Brewer of Chicago. **Dr. Herbert F. Traut,** San Francisco, is chairman of the Medical Educator's sub-section, and Dr. S. A. Cosgrove of Jersey City heads the Hospital Administration sub-section. A scientific and educational exhibit is being arranged by a committee of which Dr. J. P. Pratt of Detroit is chairman and **Dr. Ludwig Emge** of San Francisco and Dr. Frank E. Whitacre are members. Those who are not members of the Congress but who wish to attend may apply for membership by writing to the American Congress of Obstetrics and Gynecology, 24 West Ohio St., Chicago 10, Illinois.

Questionnaires to be used as a basis for determining how best to provide **civilian medical care** in event of another national emergency have been sent by the Committee on National Emergency Service of the A.M.A. to 5,000 physicians who passed the recent war years in civilian practice. Aim of the questionnaire is to develop facts as to how the civilian population was served during the war and to give the doctors who were responsible for civilian care in those years an opportunity to indicate what changes they believe should be made in the mobilization of medical service in future emergencies.

Pointing out that its extensive **services to the war wounded,** to the troops still overseas and to the veterans who have come home to unexpected emergencies must be continued, the **American Red Cross** this month has under way its drive for a national fund of $60,000,000. Announcement of the campaign said that, in addition to the war-connected services, the growing accident rate in this country makes it necessary that the Red Cross be ready wherever disaster may strike.

Psychosomatic Medicine, the bi-monthly journal sponsored by the American Society for Research in Psychosomatic Problems, Inc., will be published by Paul B. Hoeber, Inc., Medical Book Department of Harper & Brothers, New York, beginning with the issue for January-February, 1947. **Doctor Flanders Dunbar** of New York is Editor-in-Chief of the journal, and Doctor Edward Weiss of Philadelphia is president of the society for the current year.

This journal, founded in 1939 with the assistance of the Josiah Macy Jr. Foundation, was sponsored during its first five years of publication by a division of the National Research Council. Subscription price is $6.50 per year.

INFORMATION

C.M.A. Policy on Health Insurance Bills

SAM J. MCCLENDON, M.D., *San Diego*
President, California Medical Association

Advance publicity given Governor Warren's new compulsory health insurance bills, S.B. 788 and A.B. 1500, now pending before the State Legislature, apparently was designed to create an impression in the public mind that the new program is moderate and free of many of the objectionable features which characterized the legislation defeated in 1945.

That impression is false.

NEW BILLS ENDANGER PUBLIC HEALTH

The two new bills (they are identical) are now available and have been carefully analyzed. The new bills, in many respects, are more dangerous to the public health than the bills beaten two years ago.

The 1947 program, while it differs from the 1945 plan in specific provisions, still constitutes a program of compulsion to regiment doctors and their patients, to levy new payroll taxes on workers and employers—and to foist a system of politically controlled, socialized medicine on the people of California.

A PROMISE THAT CAN'T BE KEPT

The program is economically unsound, medically dangerous—and cruelly misleading in that it holds out a promise of hospital care to the sick and injured which the State is wholly incapable of keeping in face of the present critical shortage of hospital facilities.

California has a shortage of between 15,000 and 20,000 hospital beds for present needs, according to surveys which have been recently conducted—and it will take years of new hospital construction before that acute shortage can be overcome, even if means are found to finance the tremendous building program required.

There is very serious danger to the public health if the Warren compulsory health insurance program, which would cover more than 6,000,000 people, should be enacted. For every person covered under the act would be entitled to 100 days of hospitalization for each illness. Every patient, to get a benefit from his tax, would demand that he be hospitalized, because home and office calls of the doctor under this program are excluded—but medical care in the hospital, and during post-hospital recovery, is provided.

THE CRITICALLY ILL WOULD SUFFER

The chaotic conditions which would follow are all too apparent. Hospitals would be jammed with patients with minor illnesses or injuries—and people who became critically ill, in desperate need of hospitalization, would in many instances be denied the care necessary to save their lives.

On that score alone these bills should be quickly and decisively defeated, but there are many other dangerous and unworkable provisions in the program.

The program calls for a 2 per cent payroll tax on wages up to $3,000 (1 per cent to be paid by the employee and 1 per cent by the employer) to provide the following services both for the employees and their families: (1) Hospitalization for each illness or disability up to 100 days; (2) All surgical operations by doctors; (3) All medical care by doctors from and after entry into hospital, and up to 100 days; (4) All x-ray and laboratory services in and out of the hospital; (5) Drugs, biologics, plasma, etc.; (6) Obstetrical care; (7) Dentistry in hospital, except extractions and pyorrhea.

2 PER CENT TAX IS INADEQUATE

That phase of the program must have been drafted by someone more versed in socialistic ideologies than in medicine, hospital management or insurance principles—for any attempt to render such services for a 2 per cent payroll tax would result in bankruptcy for the doctors and hospitals, or a State deficit running into many millions of dollars. It should be noted, in this regard, that there is no provision in the act for payment of deficits.

The payroll tax provided in the bills would be levied against all employees (other than Christian Scientists), regardless of salary or income, who are now under the Unemployment Compensation Act (Sections 33-35), plus all employees of the State, counties, cities, districts, etc., (Sections 25-36), even including the Governor and other elective officials. While only the employees (and their employers) would be taxed, the families of employees would be entitled to medical and hospital care—and it is conservatively estimated that the group covered would number more than 6,000,000.

LOCAL TAX INCREASES

As the State, the 58 counties, all cities and districts would be required to pay the employer's tax for public employees in their jurisdiction, the act would have the effect of increasing State and local taxes—and would result in an automatic increase of all statutory debt limits (Section 127). Every taxpayer, therefore, in his dual role as an employer of public employees, would be forced to contribute toward the employer's share of the tax for government workers—in addition to paying into the

fund as employee or employer in his normal place of business.

The intent to set up a system of politically-controlled State medicine is disclaimed in Article 1, Section 1, of the bills, with a generalized statement to the effect that "the traditional relationship between patient, doctor and hospital" will not be changed. But the content of the bills, in almost every article and section which follows, belies this reassuring preamble.

So there can be no misunderstanding of the exact provisions of the bills in this regard, the State administrative bureau, which would be known as the California Health Service Authority, would have full power:

THIS IS SOCIALIZED MEDICINE

1. To fix "standards of service" (Section 209), that is to control hospital practices and medical acts and procedures;

2. To fix rates of pay to hospitals, to physicians, to laboratories and dentists (these rates need not be uniform in all parts of the State); (Section 209);

3. To extend benefits beyond those immediately authorized in the bill (Section 55-56);

4. To hire an Executive Director at $12,000 per year, plus other employees as desired (Sections 215-216);

5. To spend one-sixth of the administrative fund for financing refresher courses for doctors (Sections 158 and 210.5);

6. To carry on a propaganda campaign to influence the people and the Legislature to extend the act to include anything now left out (Section 211), and

7. To approve or reject "voluntary plans" of health insurance that desire to provide coverage for a 2 per cent of payroll premium tax.

For all practical purposes, the State bureau would hold the power of life or death over every one of the voluntary health insurance systems operating in California.

A DEATH BLOW TO VOLUNTARY SYSTEMS

And if the advocates of this legislation should be successful, the death knell already has sounded for California Physicians' Service, the doctors' own plan of pre-paid medical and hospital care, which now covers more than 400,000 people and is recognized as one of the outstanding systems in the Nation. Under the terms of S.B. 788 and A.B. 1500, California Physicians' Service is not eligible as a voluntary system—because it is a service plan rather than an insurance indemnity plan. Blue Cross Hospital Service, with its more than 650,000 members in California—and its national reputation in the voluntary field—would also be denied the right to operate.

Yet there are provisions in these bills which make pious protestations that the State program will encourage and aid the voluntary health systems!

One of the most glaring injustices which would result from enactment of the Warren compulsory health insurance bills is that more than 1,000,000 California war veterans, who served in World Wars 1 or 2, or the Spanish-American War, and who are now entitled to free medical and hospital care from the Federal Government, would be taxed arbitrarily to support a program they neither need nor want.

The American Legion, in both its National and State conventions last year, went on record as emphatically opposed to compulsory health insurance, and many of the other veterans' groups have taken similar action. Yet the State program now proposed would not only create a compulsory system, but would force veterans to pay into the fund when the Federal Government already has provided for their medical care.

California Physicians' Service, under a contract with the Veterans' Administration, has been providing medical care for veterans by their own physicians, in their own home communities, for all war-connected disabilities which do not require hospitalization. And veterans who require hospitalization are entitled to receive it without charge, as a benefit earned by their war service, in government hospitals.

Government compulsion and regimentation are abhorrent to the American people.

The California Medical Association will oppose these bills because it believes that the people of this State never would knowingly accept a system of State medicine; that they never would tolerate the type of medicine practiced in countries which have embraced compulsory health insurance. The people of California don't want a political doctor when illness strikes; they want their own doctor, and their own hospital, free from bureaucratic restraints.

Cancer Commission Refresher Course

The Cancer Commission announces a Refresher Course on neoplastic disease for physicians primarily in Northern California, to be held in San Francisco, March 27 and 28.

Expenses incident to the course are being defrayed by the American Cancer Society, California Division. Registration is limited to 175.

Applications to attend may be mailed to Dr. David A. Wood, Secretary, Cancer Commission, 450 Sutter Street, San Francisco, California.

Program for the course follows:

THURSDAY AND FRIDAY, MARCH 27 AND 28, 1947

Morning Session—9 A.M., March 27, Lane Hall, Stanford University Medical School.

Introductory Remarks—Lyle Kinney, M.D., Chairman Cancer Commission, or J. F. Rinehart, M.D., Chairman Program Committee.

CANCER OF THE ESOPHAGUS

Chairman, Robert Newell, M.D.

Recent Advances in Surgery for Cancer of the Esophagus—Gunther Nagel, M.D.—15 min.

Clinical Symptomology and Esophagoscopy — Clayton Lyon, M.D.—10 min.

X-ray Diagnosis—A. Justin Williams, M.D.—10 min.

Review of Experience in Surgery for Cancer of the Esophagus—H. Brodie Stephens, M.D.—15 min.

X-ray and Radium Therapy of Inoperable Cancer of the Esophagus—Robert Newell, M.D.—10 min.

Questions.

RECESS

CANCER OF THE STOMACH

Chairman, Arthur Bloomfield, M.D.

A round table discussion on the diagnosis and treatment of this common malignant disease. Participants: Drs. Emile Holman, H. Glenn Bell, L. H. Garland, Alvin Cox, Maurice Dailey, and Thomas Mullen.—60 min. Questions—30 min.

Luncheon.

Afternoon Session—2 P.M., March 27, Lane Hall, Stanford University Medical School.

CANCER OF THE UTERUS

Chairman, Dr. Ludwig Emge

Early Diagnosis of Cancer of the Uterus—The Use of the Vaginal Smear—Herbert F. Traut, M.D.—30 min.

Cancer of the Uterine Body—Aspiration and Other Biopsy Methods in Diagnosis—Paul Hoffmann, M.D.—15 min.

Prognosis and Treatment in Cancer of the Uterine Body—Donald W. de Carl, M.D.—15 min.

RECESS

X-ray and Radium Treatment of Cancer of the Cervix—Ludwig Emge, M.D.—30 min.

The Role of Surgery in Cancer of the Cervix—Daniel Morton, M.D.—30 min.

Questions.

Evening Meeting—8:30 P.M., March 27, Lane Hall, Stanford University Medical School.

The Program of the Cancer Commission of the California Medical Association and the American Cancer Society—Lyle Kinney, M.D., Chairman, Cancer Commission.

Cancer of the Large Intestine—Robert Scarborough, M.D.

Morning Session—9 A.M., March 28, Toland Hall, University of California, Medical School.

CANCER OF THE SKIN

Chairman, H. Glenn Bell, M.D.

The Clinical Aspects of Skin Cancer—Frances Torrey, M.D.—20 min.

Biopsy, Excisional Biopsy and Surgical Therapy of Skin Cancer—Otto Pflueger, M.D. and J. F. Rinehart, M.D.—20 min.

Irradiation Therapy of Skin Cancer—Bertram V. Low-Beer, M.D., 20 min.

Cancer of the Ear (Pinna)—Nelson Howard, M.D.—15 min.

Questions.

RECESS

Melanotic Tumors, Benign and Malignant—H. Glenn Bell, M.D.—10 min.

CANCER OF THE LIP

Chairman, H. Glenn Bell, M.D.

A round table discussion on diagnosis and methods of treatment. Participants: Drs. Leon Goldman, Emile F. Holman, Robert Newell, Robert S. Stone, David A. Wood—40 min.

Luncheon.

Afternoon Session—2 P.M., March 28, Toland Hall, University of California, Medical School.

CARCINOMA OF THE BREAST

Chairman, E. I. Bartlett, M.D.

Clinical Diagnosis and Prognosis as Related to Site and Stages Relation to Mastitis—E. I. Bartlett, M.D.—20 min.

The Gross and Microscopic Aspects of Breast Cancer—The Frozen Section—Stuart Lindsay, M.D.—15 min.

The Radical Operation for Breast Cancer and Indications for Operation—20 min.

RECESS

The Use of X-ray in Postoperative Treatment—Evelyn Siris, M.D.—15 min.

Palliative Irradiation of Advanced and Disseminated Breast Cancer—Robert Newell, M.D.—20 min.

Recent Experimental Studies on Hormonal Treatment of Inoperable Cancer of the Breast—Howard Steinbach, M.D.—15 min.

Hormonal Therapy in the Gynecologic and Mammary Sphere—C. Frederic Fluhman, M.D.—20 min.

Questions.

Letters to the Editor . . .

SOVIET "ACS" THERAPY

In 1900, Metchnikoff[3], applying the pharmacological principle that small doses of toxic drugs may stimulate rather than damage, expressed the idea that stimulation of tissues could be accomplished by the employment of small doses of antiserum specific for these tissues. Twenty-four years later, one of his students, Bogomolets[1], and his colleagues of the Ukraine, began a study of the possibility of stimulating the physiological activity of connective tissues by the injection of small doses of species-specific antireticular cytotoxic serum ("ACS").

Since then, numerous experimental and clinical successes have been reported by Soviet investigators. Among these, Varchamov[6] reported stimulation of the production of antisheep hemolysins and B. Typhosus agglutinins in rabbits. Neuman[4] reported the saving of 75 per cent of mice infected with recurrent typhus, whereas 100 per cent of the controls died. Others[1] reported increased rate of healing of experimentally produced fractures in rabbits, decreased number of takes and reduced number of metastases in transplanted cancer in mice. Clinically there was found to be an accelerated healing of severe frostbites, gangrene and war wounds, together with favorable effects in early stages of hypertension, "acute rheumatism," polyarthritis, pulmonary abscess, and tuberculosis.

In view of the numerous and remarkable claims thus made, a feeling of skepticism is natural. Because of its potential importance, however, the claims of therapeutic effects of "ACS" are worthy of attempted confirmation. This has been undertaken by Straus[5] and his associates of the Cedars of Lebanon Hospital, Los Angeles, California.

In their initial study, anti-human "ACS" was prepared by a slight modification of the Soviet technic.[2] Emulsified spleen and bone marrow from fresh human cadavers were extracted for 30 minutes at room temperature in five volumes of saline solution. After centrifugation the supernatant fluid was injected intravenously at three-day intervals in progressively increasing doses into young rabbits. Five to seven days after the sixth injection the animals were bled by cardiac puncture. The resulting antiserums were titrated by the complement-fixation reaction. At this time the titers usually varied from 2,500 to 10,000 arbitrary units.

Anti-rabbit "ACS" was prepared by the same technique, by injecting rabbit spleen and bone marrow extracts into young goats. Both the anti-human and anti-rabbit ACS were species-specific, giving negligible cross-reactions. In the undiluted state both serums may be kept at 4°C or at room temperature for a year or more with but slight deterioration. After dilution with saline solution both serums deteriorate rapidly.

The Soviet investigators claim that intravenous injection of large doses of homologous "ACS" inhibits or prevents normal healing of bone fractures; but that small doses of the same antireticular serum have the opposite effect, causing accelerated or more perfect healing. To test this claim, experimental fractures were made, under nembutal anesthesia, of the right radius and ulna of 256 healthy female rabbits, each weighing 2.25-2.50 kg. The fractures were made by means of a special osteoclast that would secure as much uniformity as possible in the location, orientation, cleanness and completeness of the fractures. Reduction of the fractures was accomplished immediately without the aid of a fluoroscope. The limbs were then encased in a light cast.

On the third day after the fracture the animals were separated at random into five groups. Each of the animals of group A was injected intravenously with 0.00125 cc. of anti-rabbit "ACS", the recommended "stimulating dose" of the Soviet investigators. Animals of group B were given 0.1 cc. anti-rabbit "ACS", the recommended "depressing" dose. Control groups C and D were given similar injections with normal goat serum. Control group E received no serum.

Roentgenograms were made of the fractured extremities at periodic intervals. On the 14th day the animals were sacrificed and the fractured forelegs stripped of soft tissues. The extent of the healing was estimated by comparing the size and character of the callus and the mobility and strength of the fracture site. The average roentgenogramic score, recorded in degrees groups (B), rising to 3.06 for the stimulated group (A). The average strength of the healed fractures was 3.41 kg. for the three control groups (C. D. E.), falling to 0.79 kg. for the "depressed" group (B), and increasing to 6.83 kg. for the "stimulated" group (A). Stimulating doses of "ACS" thus doubled the rate of normal healing of experimental fractures. Toxic doses of the same serum decreased the rate of healing to about one-fourth normal. Histological studies confirmed these differences.

The California investigators have thus confirmed the Soviet claims that small doses of homologous "ACS" accelerate connective tissue proliferation. This confirmation may go far to decrease the current skepticism of the Soviet clinical claims. The alleged acceleration of antibody production by ACS stimulation of the reticulo-endothelial system is of particular theoretical and clinical interest. This claim is now under investigation.

W. H. Manwaring, Stanford University.

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BOOK REVIEWS

THE PERSONALITY OF THE PRESCHOOL CHILD. By Werner Wolff, Ph.D., Professor of Psychology, Bard College. Grune & Stratton, New York. 1946. Price $5.00.

"The Personality of the Preschool Child" by Werner Wolff, Ph.D., is a timely book. It is an odd fact that all adults have lived through the childhood period and yet so very few understand child psychology or the child's personality. This book is an attempt to study the ways and means of understanding a child's point of view. The book compares, first, the mind of the child and adult, secondly the emotions of the child and adult, and then goes on to discuss the child's concept of reality and his growth in developing an as individual. Various methods of interpreting the child by his play, his growing and other methods of expressing himself are discussed. The book is not written for parents; it is a book that should be read by professional people interested in the child, such as child psychologists, psychiatrists, pediatricians and educators. Even among these it is necessary that the individual be somewhat familiar with methods used in studying children in order to get the most out of the book. Unfortunately, relatively few pediatricians have much of this background.

For those who are not interested in or familiar with some of the newer methods of studying child psychology it might be well to read the last half of the book first, starting with Chapter 10 which deals with the educational bridge between two worlds, referring to the child world and the adult world. Certainly every pediatrician should be aware of the number of problems in his practice which are related to emotional disturbances rather than physical defects. Many of these problems arise merely from the child being fenced in by adults, so completely surrounded by them and his life ordered by them that the child has no opportunity to develop his own personality and against which encirclement he may defend himself either by behaving as a little caged animal or by retreating into a corner and sucking his thumb.

CLINICAL HEMATOLOGY. By Maxwell M. Wintrobe, M. D., Ph.D., Professor of Medicine, University of Utah, School of Medicine, Salt Lake City, Utah; Formerly Associate in Medicine, Johns Hopkins University, Associate Physician, Johns Hopkins Hospital, and Physician-in-Charge, Clinic for Nutritional, Gastro-Intestinal and Homopoietic Disorders, Baltimore, Maryland. Second Edition, enlarged and thoroughly revised, published October, 1946. Octavo, 862 pages, illustrated with 197 engravings and 14 plates, 10 in color. Cloth, $11.00.

It is a pleasure to review this excellent book on Clinical Hematology written by Professor Maxwell M. Wintrobe. The author's contributions to hematology from the viewpoint of both normal and abnormal physiology give him a background that enables him to bring together the tremendous amount of data found between the covers of this book.

The author, in this second edition, has increased the size of the book by seventy pages. There have been added more engravings and colored plates. These are essential to a good text on hematology, but their cost of reproduction is so prohibitive that an author must restrain himself in the number of his selections.

There has been an expansion of a fascinating chapter on the metabolism of hemoglobin which encompasses the manufacture and destruction of the red blood cell.

The section on the Rh factor, and its various sub-groups, and the role it plays in the destruction of the red blood cell following transfusion reactions and hemolytic diseases of the newborn, has been considerably extended. There is an entirely new section on folic acid and the role it plays in the maturation of the red blood cell.

There is some discussion on the use of nitrogen mustards in the treatment of Hodgkins Disease and Leukemia.

A great deal has been added in the way of clinical description of diseases and their variations that make the book of practical value to the general practitioner. The Lymphomas, Monocytic Leukemias and Infectious Mononucleosos are but a few of the conditions that may be mentioned in this category.

The text contains usable laboratory procedures and methods of treatment that enhance its value. This book should be designated as the standard text for the hematologist, the practitioner and the medical student.

THE COMPLEAT PEDIATRICIAN, Fifth Edition, Practical Diagnostic, Therapeutic and Preventive Pediatrics. By W. C. Davison, Professor of Pediatrics, Duke University School of Medicine, Formerly Acting Pediatrician in Charge, The Johns Hopkins Hospital. Duke University Press, Durham, N. C. Price $3.75.

Like earlier editions, this fifth edition of "The Compleat Pediatrician" is a valuable handbook, not only for a pediatrician, but for the general practitioner. It is first of all a "differential diagnosis" based on symptoms and signs. The probabilities, and possibilities, both near and remote, which certain symptoms invoke are listed. The list is in order of frequency of occurrence based on voluminous hospital and dispensary records. Secondly, the book serves as a clinical laboratory manual. Thirdly, it is a handbook of pediatric therapy. Here perhaps the author is a little generous in including therapy of questionable value as well as drugs and biologics of proven value. Finally there are included some very valuable tables on normal growth and development, on food composition and diets, on drug dosages, and on clinical chemical norms.

The best description of this book is that of the author himself who writes in the preface, "Indeed it might be called a pediatric almanac." Dr. Davison goes on to express the hope "that this book may serve as a 'ready reminder' to be carried in a physician's pocket or bag to jog his memory on possibilities, but it cannot do his thinking for him." The reviewer has used earlier editions of this book in this way and has found them to be excellent "ready reminders." He will use the fifth edition similarly.

HENRY SEWALL, Physiologist and Physician. By Gerald R. Webb and Desmond Powell. The Johns Hopkins Press, Baltimore 18, Maryland. 1946. Price $2.75.

Dr. Webb and Mr. Powell have presented a biography in a delightful literary style of a great physiologist, physician and teacher. The little book of two hundred pages portrays with engaging interest the romantic career of a descendant of a distinguished family who was annoyed at the "exalted exercise of the vain impulse which leads to search for noble tributaries of the ancestral stream"—who spoke of himself as a Virginian by mistake, his parents being temporarily away from their Baltimore home.

From his youth he was possessed of what Huxley called the "devine dipsomania of original research"—also possessed of a fiery, picturesque and murderous temper refined withal by early ardent religious training. His sarcasm was scorching and his advice was incisive. In dismissing a young man who later became a well known scientist he thunderously gave expression to the wish that God would

send him another assistant, "Any fool would be an improvement," he roared.

In engaging another he gave the following advice, "Claude Bernard was the greatest physiologist that ever lived. He knew what it takes to make a good research man and summed it up in two words, curiosity and ignorance. One of these qualities you have in superlative degree. Prove the other and we will get along famously."

The romance of his life of research and teaching involves the close friendship of his mentors, Dr. H. Newell Martin, Sir Michael Foster and Carl Ludwig, of his confreres on the faculty of Johns Hopkins and at Ann Arbor and his devotion to a devoted wife. It involves his seeking for health at Saranac with Trudeau and in the climate of the mountains while practicing medicine and teaching in Colorado. It involves his fiery personality and genius as a physiologist and as a driving and inspiring teacher.

His experiments with snake venom in 1887 marked the advance from the purely bacteriological concept of immunology, the use of attenuated bacilli, to the new field of biochemical research and antitoxins. He was followed by Calmette, and by von Behring and Roux, Kolle and Wassermann.

For those who enjoy the contemplation of the life of a sturdy character moving among men making medical history at a time when modern medical science was rapidly coming into full bloom—a story well told—this book may well be recommended.

SEGMENTAL NEURALGIA IN PAINFUL SYNDROMES. By Bernard Judovich, B.S., M.D., and William Bates, B.S., M.D. Foreword by Joseph C. Yaskin, M.D. Second Edition. 178 Illustrations. 320 Pages. F. A. Davis Company, Philadelphia, Publishers. 1946. Price $5.00.

The second edition of this book on the segmental neuralgias confirms the good results obtained by nerve blocks with the ammonium salts as well as with the 2 per cent procaine or with the two anesthetics in one solution.

The pitcher plant distillate is replaced by its active principle, ammonium chloride or sulfate, which acts on the sensory nerves relieving neuralgic pain without change in skin sensation and having no effect upon motor nerves. It has no effect on pain which originates from muscles, ligaments, tendons, blood vessels and sympathetic ganglia and fibers.

This book covers in particular the intercostal neuralgias and abdominal wall neuralgias which have at times simulated the pain of visceral disease. Unless one determines the type of pain and tenderness in the patient, needless and useless operations may be performed for a segmental neuralgia which might be due to toxic absorption, poor posture, trauma, arthritis of the spine or malignant metastases, and which may be relieved by physical therapy, postural corrective exercises and nerve blocks.

In attempting to cover the field of pain relieved by nerve blocks, trigeminal neuralgia is included. Chapter 13 on herpes zoster reports good results in the acute phase by paravertebral nerve block, but no real relief of pain in the chronic cases. Although the authors suggest that changes take place in the sympathetic ganglia in the chronic cases, they have not attempted to give relief, as others have, by sympathetic blockage.

The technique for infiltration of the anterior scalene muscle is an improvement and fairly safe.

The illustrations are helpful and make this book of value to everyone troubled with the not too infrequent problem of determining the origin of pain and its proper treatment.

WHAT IS HEART DISEASE. By W. H. Gordon, M.D., F.A.C.P., Diplomate of the American Board of Internal Medicine, Head of Medical Section, Lubbock Memorial Hospital and Clinic, Lubbock, Texas. Grune & Stratton, New York. 1946. Price $2.50.

The author has a sound, optimistic approach to the problem of presenting heart disease to the patient. The generally reassuring tone is constructive because patients who take the time to read popular medical books are usually the most anxious ones. The book consists of nine chapters containing brief discussions of various cardiac problems, and encyclopedia-like definitions of some terms used in cardiology.

The author is to be complimented for his clear-cut, understandable and well-illustrated presentations of the function of the normal and abnormal heart. The last chapter: "Symptoms erroneously thought to indicate heart disease" is excellent. One may question, however, the need for including in the presentation some rare forms of heart disease, or such subjects as history taking, physical examination, or description of cardiac sounds and murmurs. One regrets also that so little space is devoted to various aspects of management of a patient with heart disease, the understanding of which makes the task of the physician, and the patient's life, easier.

On the whole, the book will be found interesting by a patient who merely wants to know more what his doctor is talking about. It will be somewhat of a disappointment to the thoughtful patient who wants guidance in how to cooperate with his physician.

MONGOLISM AND CRETINISM. By Clemens E. Benda, M.D., Director, Wallace Research Laboratory for the Study of Mental Deficiency, Wrentham, Mass., Instructor in Neuropathology, Harvard Medical School, Assistant in Psychiatry, Massachusetts General Hospital, Lecturer, Postgraduate Seminar, Massachusetts Department of Mental Health. Copyright 1946. Grune & Stratton, New York. Price $6.50.

Benda describes mongolism as "pituitary cretinism" due to congenital hypopituitarism and calls the condition acromicria. The opposite of mongolism is acromegaly. His thesis is based upon the pathology of the pituitary gland suggesting its deficiency and he states that all endocrine glands show the effect of this. Twelve per cent of mongols have a cretinoid condition of the thyroid gland and in the other 88 per cent the thyroid stagnates although it seems fit for some normal function. Mongolism is an experiment by nature to produce humans without adequate endocrine function. The mongol brain with its mental deficiency is the result of chronic anoxemia or hypoglycemia. Benda recommends therapy with thyrotropic and thyroid hormones among the other usual procedures. There is a chapter on the relation of mongolism to the mother's pre-natal condition and some theoretical remarks on prevention.

Benda constantly contrasts and compares mongolism with cretinism. He states that the latter is not due primarily to thyroid deficiency and that the thyroid disease only occurs in the course of a general degeneration. He feels that the brain pathology of cretinism is a metabolic defect produced by anoxia.

There are good clinical and pathological descriptions of mongolism. These should be checked by other pathologists, as the findings are somewhat different from previously reported autopsies.

This book is recommended for those dealing with mongolism, particularly pediatric neuropsychiatrists, pathologists and institutional workers.

MEDICAL JURISPRUDENCE

MALPRACTICE—SUFFICIENCY OF EVIDENCE FROM WHICH A JURY MAY DRAW CONCLUSIONS

PEART, BARATY & HASSARD, *San Francisco*

A very recent case, (Dec. 24, 1946) 77 A.C.A. 432, decided by the District Court of Appeal of the State of California discussed the medical procedures and degree of skill which a physician should exercise in treating an injury. The facts giving rise to the case were as follows:

Mr. X while working for a shipbuilding corporation suffered a bruise and laceration between the distal and medial phlanges of his middle left finger about the size of a dime, when a steel beam fell upon it. He reported at once to the first aid hospital where under the direction of Doctor W., an employee of the defendant doctor, he extended the injured member for ten minutes into the radiation of the x-rays applied in conjunction with a fluoroscope while the physician examined the injury. The injury was then soaked in a solution of epsom salts after which it was dressed with ointment and bandaged. Mr. X returned at intervals of two or three days for three weeks for the treatments while he continued at his work. Although he favored the finger it did not cause him any distress. After the sixth treatment the injury healed. About four days later it broke open, making a wound about half an inch in length. Thereafter it habitually healed in approximately a week and broke open again in four days. This continued for almost seven months, during which time Mr. X did not report this capricious behavior to anyone in the hospital. He returned to the hospital on July 3, 1942, when a callus had formed over the wound, and an x-ray was made of the injured area. He then obtained from the hospital a piece of adhesive tape and wrapped it around the sore spot. It remained for four or five days during which he felt a burning, irritating pain which had first occurred about a month prior to the formation of the callus. On removing the tape the callus came off. He then returned to the hospital where he was referred to the defendant doctor. Mr. X discontinued work July 15. After an examination by an associate of the defendant doctor at the latter's office respondent was examined next on August 14, 1942, by a Dr. F, a specialist in dermatology. At that time the doctor found on the anterior surface of the finger an arthrempysis about a half inch in diameter with a small ulcer in the center. The posterior surface was smooth and red. Basing his opinion upon such examination and upon the history given by the patient, Dr. F testified that his diagnosis was "x-ray ulcer with dermatitis."

On August 31, 1942, Mr. X was examined by a Dr. M who diagnosed the wound as a trophic ulcer, consistent with roentgen dermatitis. Thereafter Dr. M saw Mr. X twice in September and twice in October and administered medicaments: pantocain and sulpha drugs to the wound, leaves of cactus plant, radon ointment, lanolin and vaseline. Dr. M then recommended excision of the ulcer, which was performed by others at the hospital. This operation did not clear up the infection although the excision was down to the tendon. Mr. X suffered thereafter from a red rash with water blisters as a result of his allergic reaction to the sulpha drugs which had been administered and he continued to have pain which could be relieved only by codein. Dr. M then recommended amputation of the entire finger to which the defendant doctor acquiesced and the operation was performed December 1, 1942. Thereafter swelling progressed up Mr. X's arm and the increased temperature and redness of the skin necessitated the opening of the wound on December 17. The wound healed slowly. Mr. X was discharged from the hospital February 10, 1943.

At the trial Mr. X produced four expert witnesses who testified that Mr. X had a trophic ulceration with dermatitis consistent with x-ray burn. Other expert testimony was given to the effect that the record of Mr. X, afer the injury, revealed that the injury was due to prolonged x-ray radiation. The jury held for Mr. X and awarded him damages against the defendant physician. In its opinion the District Court of Appeal held that the jury had ample competent proof that the injuries suffered by Mr. X were the result of a radiation burn. Discrepancies in the testimony, contradictory statements by Mr. X and possibilities that the ulcer might have been caused by trauma or other influences were resolved, the court stated, by the jury in holding for Mr. X. The court then enunciated the rule that in such cases it is not necessary to demonstrate conclusively the negligence of the physician, holding that a preponderance of the evidence only is required, and the fact finders may within reasonable limitations draw their own inferences from proven facts; also, they may reject alternative opinions while accepting the primary opinions of experts. The court then stated that: "Mr. X's testimony that his finger was held under the influence of x-rays while being examined through a fluoroscope; his immediate suffering with intense pain; the excision of the ulcer; the amputation of the finger; the pus-draining operation; the pain in his arm; confinement to the hospital; loss of power in his hand; all warrant the finding that the sole and efficient cause of Mr. X's injuries was the negligence of the physician who exposed his hand to the radiation."

It was contended by the defendant doctor that Mr. X was guilty of contributory negligence and did not exercise reasonable diligence in caring for his injury and did not use reasonable means to prevent its aggravation. However, the jury disregarded this argument and held for Mr. X.

PROGRAM AND PRE-CONVENTION REPORTS

for the

CALIFORNIA MEDICAL ASSOCIATION

Seventy-sixth Annual Session

Los Angeles—April 30-May 3, 1947

Biltmore Hotel

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CANCER COMMISSION

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President of C.M.A.

JOHN W. CLINE
President-Elect

E. VINCENT ASKEY
Speaker of the House of Delegates

Guest Speakers

JAMES T. PRIESTLEY, Guest Speaker
Mayo Clinic, Rochester, Minnesota

A. W. OUGHTERSON, Guest Speaker
Medical Director of the American Cancer Society
New York City

HOBART A. REIMANN, Guest Speaker
Professor of Medicine, Jefferson Medical College
Philadelphia

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DELEGATES EX OFFICIO (21)

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E. Earl Moody (1947).....Councilor-at-Large
C. V. Thompson (1949).....Councilor-at-Large
Louis J. Regan (1949).....Councilor-at-Large

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Ergo A. Majors	James M. Neil
Albert M. Meads	James Raphael
William W. Reich	Hobart Rogers
T. E. Reynolds	D. D. Stafford
Stanley R. Truman	

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Hollis L. Carey	J. G. Hepplewhite

Delegates	*Alternates*
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J. M. McCullough	J. M. Boomer
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Elmer Belt	John W. Beeman
John E. Bergmann	Frederick A. Bennetts
Clarence J. Berne	Lewis P. Bolander
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Peter Blong	Hans V. Briesen
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Richard O. Bullis	Ben L. Bryant
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John A. Chapman	Rafe C. Chaffin
Donald A. Charnock	Finis G. Cooper

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Delegates	*Alternates*
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Harold E. Crowe	George R. Dunlevy
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C. M. Hadley	Carroll A. Herrmann
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J. Needham Martin	Leonard Taylor

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John Hunt Shephard	Burt Davis
Cletus Sullivan	Dudley Fagerstrom
Don Threlfall	Charles A. Fernish

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A. A. Morrison	C. G. Drace

Yolo County (1)

Earl H. Gray	Ray Nichols

Yuba-Sutter-Colusa County (1)

Stanley R. Parkinson	Neal M. Loomis

House of Delegates Meetings

44th ANNUAL SESSION

Special Notice.—The House of Delegates will convene for organization and other business in the Music Room of the Hotel Biltmore, on Wednesday afternoon, at 4:30 p.m., May 1, 1947.

Speaker, E. VINCENT ASKEY, *Los Angeles*
Vice-Speaker, L. A. ALESEN, *Los Angeles*
Secretary, L. HENRY GARLAND, *San Francisco*

AGENDA

FIRST MEETING

Wednesday Afternoon, May 1, 1947, at 4:30 p.m.

Order of Business

1. Call to order.
2. Report of Committee on Credentials, and Organization of the House of Delegates.
3. Roll call.
4. Announcement and approval of Reference Committees.
   (*a*) Committee on Credentials. (Delegates must register with the Committee.)
   (*b*) Reference Committee on the Reports of Officers and Standing Committees (Reference Committee No. 1). Note: Will consider also: Reports of County Society Secretaries.
   (*c*) Reference Committee on the Report of the Council and the Reports of the Secretary-Treasurer and Executive Secretary. (Reference Committee No. 2).
   (*d*) Reference Committee on Resolutions, Amendments to the Constitution and By-laws, and New and Miscellaneous Business. (Reference Committee No. 3.)
5. Address by President—Sam J. McClendon.
6. Miscellaneous announcements by the speaker. (Stenographic service, to secure triplicate copies of resolutions, etc.)
7. Report of the Council—Edwin L. Bruck, Chairman.
8. Report of the Trustees of the California Medical Association—Sam J. McClendon, President.
9. Report of the Auditing Committee—Sidney J. Shipman, Chairman.
10. Report of the Secretary—L. Henry Garland.
11. Report of the Executive Secretary—John Hunton.
12. Recess.—(Note: At the time (8:30 p.m. on Wednesday) the House of Delegates will recess. Elected and ex-officio members of the House will then convene under the chairmanship of the President of the Board of Trustees of California Physicians' Service, to function with Board of Administrative Members of California Physicians' Service. With the adjournment of the meeting of C.P.S. Administrative members, the C.M.A. House of Delegates will convene, to act again as the House of Delegates of the California Medical Association.)

Meeting of Administrative Members of California Physicians' Service

1. Roll call (8:30 p.m. on Wednesday).
2. Report of the President—Dr. Lowell S. Goin.
3. Report of the Secretary—Dr. Chester L. Cooley.
4. C.P.S. Administration Business Report, by the Executive Director—Mr. W. W. Bowman.
5. Appointment of Nominating Committee for Trustees and Administrative Members at Large.
6. Introduction of Resolutions.
7. Recess—for 24 hours. (Time of reconvening will be stated.)
8. Consideration of the Report of the Nominating Committee.
9. Consideration of resolutions.
10. New business.

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13. Report of the Editor—Dwight L. Wilbur.
14. Reports of District Councilors.
15. Reports of Councilors-at-large.
16. Report of General Counsel—Hartley F. Peart.
17. Reports of Standing and Special Committees:
    A. Standing Committees:
    (*a*) Executive Committee—Sidney J. Shipman.
    (*b*) Committee on Associated Societies and Technical Groups—Anthony B. Diepenbrock.
    (*c*) Committee on Audits—Sidney J. Shipman.
    (*d*) Committee on Health and Public Instruction—George M. Uhl.
    (*e*) Committee on History and Obituaries—Morton R. Gibbons, Sr.
    (*f*) Committee on Hospitals, Dispensaries, and Clinics—Clarence E. Rees.
    (*g*) Committee on Industrial Practice—Donald Cass.
    (*h*) Committee on Medical Defense—William A. Key.
    (*i*) Committee on Medical Economics—H. Gordon MacLean.
    (*j*) Committee on Medical Education and Medical Institutions—B. O. Raulston.
    (*k*) Committee on Organization and Membership—Carl L. Mulfinger.
    (*l*) Committee on Postgraduate Activities—John C. Ruddock.
    (*m*) Committee on Publications—George W. Walker.
    (*n*) Committee on Public Policy and Legislation—Dwight H. Murray.
    (*o*) Committee on Scientific Work (Annual Session)—L. Henry Garland.
    (*p*) Cancer Commission—Lyell C. Kinney.
    (*q*) Editorial Board—Dwight L. Wilbur.
    B. Special Committees:
    (*a*) Delegates to the American Medical Association—Sam J. McClendon.
    (*b*) Physicians' Benevolence Committee—Axcel E. Anderson.
    (*c*) Advisory Planning Committee—John Hunton.
18. Old and Unfinished Business.
    (*a*) Constitutional Amendments.
19. New Business.

SECOND MEETING

Friday, May 2, at 4:30 p.m. In Music Room

Order of Business

1. Call to order.
2. Supplemental Report of Credentials Committee.
3. Roll Call.
4. Secretary's announcement of Council's selection of place for the 1948 annual session.
5. Election of Officers:
   (*a*) *President-Elect.*
   (*b*) *Speaker.*
   (*c*) *Vice-Speaker.*
   (*d*) *District Councilors***

   First District—Herbert A. Johnston, Anaheim (term expiring).
   First District—Imperial, Orange, Riverside, San Bernardino and San Diego counties.
   Fourth District—Axcel E. Anderson, Fresno (term expiring).
   Fourth District—Calaveras, Fresno, Kings, Madera, Mariposa, Merced, San Joaquin, Stanislaus, Tulare and Tuolumne counties.
   Seventh District—Lloyd E. Kindall, Oakland (term expiring).
   Seventh District—Alameda and Contra Costa counties.

   (*e*) *Councilors-at-Large:*
   (Note.—*Each vacancy among Councilors-at-Large, Delegates and Alternates is considered in turn. Each vacancy is voted on separately.*)
   Sidney J. Shipman, San Francisco (term expiring).
   E. Earl Moody, Los Angeles (term expiring).

   (*f*) *Delegates to the American Medical Association:*
   Delegates are elected for two calendar years. At this session of the C.M.A. House of Delegates, terms of Delegates elected for calendar years 1948-1949 will expire on December 31, 1949.
   For terms: January 1, 1948-December 31, 1949
   Incumbents
   (*a*) Robertson Ward, San Francsco (term expiring).
   (*b*) Sam J. McClendon, San Diego (term expiring).
   (*c*) Lowell S. Goin, Los Angeles (term expiring).
   (*d*) John W. Green, Vallejo (term expiring).

(g) *Alternates to the American Medical Association:*
- (a) Anthony B. Diepenbrock, San Francisco (Alternate to Robertson Ward).
- (b) Bon O. Adams, Riverside (Alternate to Sam J. McClendon).
- (c) Louis J. Regan, Los Angeles (Alternate to Lowell S. Goin).
- (d) H. Randall Madeley, Vallejo (Alternate to John W. Green).

(h) Election of new delegate to A.M.A. (term expiring December 31, 1948).

(i) Election of alternate to A.M.A. delegate (term expiring December 31, 1948).

6. Announcement by Secretary.
Council's nominations of Members of Standing Committees. (For approval by the House of Delegates.)
7. Reports of Reference Committees:
   (a) Report of Reference Committee Number 1, on "Reports of Officers and Standing Committees."
   (b) Report of Reference Committee Number 2, on "Report of the Council, and Reports of Secretary-Treasurer, and Executive Secretary."
   (c) Report of Reference Committee Number 3, on "Resolutions, Amendments to the Constitution and By-Laws, and New and Miscellaneous Business."
8. Unfinished Business.
9. New Business.
10. Presentation of Officers:
   President
   President-Elect
   Speaker
   Vice-Speaker
11. Presentation of Certificate to Retiring President—Sam J. McClendon.
12. Approval of Minutes. (Committee to edit.)
13. Adjournment.

E. VINCENT ASKEY, *Speaker.*
L. HENRY GARLAND, *Secretary.*

** *Procedure of nomination of District Councilors is outlined in paragraph 3 of Article VII, Section 1, of C.M.A. constitution, adopted on May 8, 1940:*

The nine district Councilors shall be elected as follows:

Prior to the time set for election of district Councilors, the delegates of each Councilor district for which a councilorship is about to become vacant, shall submit in writing to the Secretary-Treasurer the names of one or more nominees to fill the said vacancy.

The Secretary-Treasurer shall transmit the names of such nominee or nominees so submitted to him to the House of Delegates on or before the time set for the election.

A vote shall be taken by the House of Delegates upon the nominee or nominees so submitted and, in the event that only one nominee has been submitted, the House of Delegates may, by a majority vote, either elect or refuse to elect said nominee.

If the House of Delegates shall reject the sole nominee of the delegates from the councilorship district concerned, then said delegates must immediately thereafter submit an additional nominee or nominees and the House shall proceed to vote thereon; if there is but one nominee, the House may elect or reject.

If, after such time as the Speaker may allow, delegates within such councilor district fail to submit an additional nominee or nominees, the House of Delegates may then proceed to make nominations from the floor of the House and a vote shall then be taken by the House of Delegates to determine who shall be elected to the vacant councilorship.

All nominees for district councilorships must be members in good standing, residing within the district in which the vacancy exists.

Proposed Amendments To C.M.A. Constitution

(FIRST PUBLICATION)

First publication of two resolutions to amend the Constitution of the California Medical Association, which were introduced in the House of Delegates at the 1946 annual meeting, is made herewith:

RESOLUTION

Be It Resolved, That Section 12 of Article X of the Constitution of the California Medical Association is hereby repealed.

RESOLUTION

Resolved, That the Constitution of the California Medical Association shall be amended:

1. By deleting from Article VII, Section 1, Paragraph 4, the words, in line 6 thereof, "or more";

2. By adding to Article VII, Section 1, Paragraph 4, at the end thereof, the words, "and provided further that when any one councilor district shall have more than 1,500 members, one additional councilor-at-large for each additional 750 members or major fraction thereof shall be elected from its membership";

3. By adding to Article X, Section 1, Paragraph 1, at the end thereof, the words, "plus the additional councilors-at-large, as provided herein, in Article VII, Section 1";

4. By adding to Article X, Section 6, Paragraph 1, at the end thereof, the sentence, "Additional councilors-at-large, as provided herein, shall be elected each year when a vacancy exists or is created by increased membership in a councilor district"; and

5. By changing Article X, Section 9, Paragraph 3, thereof, to read as follows: "When a component county society shall have fifteen hundred members two of the councilors-at-large shall be elected from its membership; and when a component county society shall have more than 1,500 members, one additional councilor-at-large for each additional 750 members or major fraction thereof, as herein provided, shall be elected from its membership. The district councilor and two of the councilors-at-large shall be elected in different years in calendar sequence. The additional councilors-at-large shall be elected as herein provided."

SCIENTIFIC ASSEMBLIES

GENERAL AND SECTIONAL

General Meetings

First General Meeting

Wednesday, April 30. 10:00 A.M. Ball Room

Chairman, Sam J. McClendon, M.D., President

10:00 A.M.—Invocation—*Msgr. Thomas J. O'Dwyer.*

10:05 A.M.—Address of Welcome—*E. T. Remmen, M.D., President, Los Angeles County Medical Association.*

10:10 A.M.—Greetings from the Woman's Auxiliary —*Mrs. H. E. Henderson, President, Woman's Auxiliary to the California Medical Association.*

10:20 A.M.—Address of the President—*Sam J. McClendon, M.D., San Diego.*

10:40 A.M.—Planning the Attack on Cancer—*A. W. Oughterson, M.D., New York City.*

Paper No. 1. Since no single method of attack on the cancer problem can insure success there is need for an overall strategic plan. The objectives of such a plan are discussed in relation to the cause, prevention, and cure of cancer. Two means of achieving the objective are discussed: (1) the maximum use of the methods already available for the prevention, diagnosis, and treatment of cancer, and (2) research for new methods.

11:20 A.M.—Infectious (Viral) Hepatitis and the Public Health—*Albert M. Snell, M.D., Rochester, Minnesota.*

Paper No. 2. The recent global epidemic of viral hepatitis has left in its wake a number of problems which are of general importance. These include (1) the increased incidence of fulminant hepatitis, (2) the probability that the icterogenic agent may be transmitted by blood and blood products, and (3) the residues of hepatic damage which may progress to a more serious state. The clinical implications of these and other related problems will be discussed.

Second General Meeting

Friday, May 2. 2:00 P.M. Ball Room

Chairmen: Francis L. Chamberlain, M.D., San Francisco
H. Brodie Stephens, M.D., San Francisco

2:00 P.M.—Clinical and Physiologic Considerations in the Surgical Treatment of Duodenal Ulcer —*James T. Priestley, M.D., Rochester, Minnesota.*

Paper No. 3. The normal and pathologic physiology of the stomach and duodenum is considered in relationship with the surgical treatment of duodenal ulcer. Certain technical and clinical factors thought to be significant in the management of ulcer are discussed. Current experience with vagotomy is reviewed.

2:30 P.M.—Periodic Diseases—*Hobart A. Reimann, M.D., Philadelphia, Pennsylvania.*

Paper No. 4. There are a number of conditions which recur at regular intervals of day or weeks and persist for many years without incapacitating patients except during episodes. Among these are periodic fever, cyclic neutropenia, recurrent purpura, intermittent hydrarthrosis, recurrent myasthenia and familial periodic paralysis. Representative cases of some of these diseases are to be presented and discussed.

3:00 P.M.—The Diagnostic Problem in Gastro-Intestinal Cancer—*A. W. Oughterson, M.D., New York City.*

Paper No. 5. Since half of the total mortality from cancer is due to cancer of the gastro-intestinal tract, this problem deserves special consideration. Most of these cancers are susceptible to cure by surgery if diagnosed and treated in time. The procedure needed for early diagnosis of gastro-intestinal cancer discussed.

3:00 P.M.—Recess.

CLINICAL-PATHOLOGICAL CONFERENCE

3:35 P.M.—Case No. 1: Pathologist John Tragerman, M.D., Los Angeles; with Clinician Albert M. Snell, M.D., Rochester, Minn.

Paper No. 6.

4:05 P.M.—Case No. 2: Pathologist William O. Russell, M.D., Santa Barbara; with Clinician Hobart Reimann, M.D., Philadelphia, Pennsylvania.

Paper No. 7.

4:35 P.M.—Case No. 3: Pathologist Robert Dennis, M.D., Santa Rosa; with Clinician Edwin L. Bruck, M.D., San Francisco.

Paper No. 8.

Section Meetings

FRANCIS L. CHAMBERLAIN
Chairman, General Medicine

HOWARD O. DENNIS
Secretary, General Medicine

SECTION ON GENERAL MEDICINE

Francis L. Chamberlain, M.D., San Francisco, *Chairman*
Howard O. Dennis, M.D., Beverly Hills, *Secretary*
George B. Robson, M.D., San Francisco, *Assistant Secretary*

Wednesday, April 30. 2:00 P.M. Ball Room
Joint Meeting with Sections on Public Health, and Pediatrics

PANEL DISCUSSION ON VIRUS DISEASES

Moderator: Hobart A. Reimann, M.D.,
Philadelphia, Pennsylvania

2:00 P.M.—The Etiology and Epidemiology of the Virus Group of Encephalitides—*William McD. Hammon, M.D., San Francisco.*

Paper No. 9. The viruses chiefly responsible for the production of encephalitis in man and procedures for their detection will be noted with particular attention to those agents of importance in California. Recent developments in knowledge of mode of transmission and possible approaches to control of these virus diseases will be discussed.

2:20 P.M.—Clinical Aspects of the Encephalitides—*Paul Hamilton, M.D., San Marino.*

Paper No. 10. The diagnosis of encephalitis may be difficult. An etiologic diagnosis based on clinical findings is normally impossible. The clinical considerations which help to distinguish encephalitis from other diseases are considered, and brief comments are offered on some features usually characteristic of certain etiologic groups.

2:40 P.M.—Present Concepts of Epidemiology of Poliomyelitis—*Norman Nelson, M.D., Los Angeles.*

Paper No. 11. The virus of poliomyelitis, because of its specificity, has been a relatively difficult organism with which to work in a laboratory. Immunological studies, based upon experimentally produced disease in animals, have resulted in such a mass of difficult interpreted evidence that one is forced to return to a restudy of the disease as it occurs in man.

A Study of Age Incidence and Epidemicity as related to Virgin Soil Outbreaks, Early Poliomyelitis, Geographic Distribution, and Institutional Outbreaks, indicates: 1. That a very definite status of acquired immunity in poliomyelitis exists in the population at large; 2. Epidemics of poliomyelitis have increased throughout the world wherever hygiene and sanitation have allowed the building up of susceptibles; 3. The earlier the age at which infection with the virus of poliomyelitis takes place, the less serious is the disease produced; 4. It may well be that, paradoxically, we have actually increased the incidence of polimyelitis disease while cutting down the general rate of infection through better hygiene and sanitation by moving the age of infection into the older age groups.

3:00 P.M.—Discussion.

3:15 P.M.—Viral Pneumonias—*Hobart A. Reimann, M.D., Philadelphia, Pennsylvania.*

Paper No. 12.

3:35 P.M.—Recent Advances in Diagnosis and Prevention of Mumps and Measles—*Harold E. Pearson, M.D., Los Angeles.*

Paper No. 13. New laboratory diagnostic procedures are now available for mumps. The cultivation of the virus of mumps and measles in embryonated eggs has permitted the development of vaccines; the use of such vaccines in prevention of the diseases is discussed.

3:55 P.M.—Influenza—A Review of Recent Developments—*Monroe D. Eaton, M.D., Berkeley.*

Paper No. 14. The periodicity of epidemics of influenza A and B and the significance of related sporadic cases and localized outbreaks will be discussed. Methods, indications, and difficulties of immunization with chick embryo vaccines and recent work on the chemotherapy of the bacterial components in influenzal pneumonia will be reviewed.

4:15 P.M.—Discussion.

4:30 P.M.—Virus Studies of Etiology of Diarrhea of the Newborn—*Gordon Meiklejohn, M.D., Berkeley.*

Paper No. 15. Investigations have been directed toward isolating and propagating a filter-passing agent and to establishing its etiological relationship to this disease. The method of scarification of the rabbit's cornea, described by Buddingh and Dodds,

and other methods have been used to study material from recent California epidemics.

4:50 P.M.—Discussion.

5:00 P.M.—Meeting and Election of Officers of California Society of Internal Medicine.

Thursday, May 1. 9:30 A.M. Ball Room

Joint Meeting with Sections on General Surgery, Radiology, and General Practice

PANEL DISCUSSION ON DISEASES OF THE STOMACH

Moderator: Albert M. Snell, M.D., Rochester, Minnesota

9:30 A.M.—Psychosomatic Aspects of Stomach Diseases—*Meyer A. Zeligs, M.D., San Francisco.*

Paper No. 16. The important role which emotional and personality factors play in the production of disturbances of gastric functions will be discussed for the general medical practitioner. A simplified explanation of psychodynamic mechanisms in gastric disease, especially peptic ulcer will be presented.

9:50 A.M.—Gastric Bleeding—*Carleton Mathewson, Jr., M.D., San Francisco.*

Paper No. 17. Differential diagnosis and surgical treatment of gastric hemorrhage. Surgical management is applicable mainly to two distinct groups of gastric bleeders; (1) Massive hemorrhage that requires emergency operation to save life, and (2) chronic persistent bleeding not controlled by conservative medical management.

10:10 A.M.—Treatment vs. Prevention of Peptic Ulcer—*Theodore L. Althausen, M.D., San Francisco.*

Paper No. 18. The effectiveness of medical treatment for uncomplicated peptic ulcer will be considered. The incidence of recurrences of peptic ulcer under different types of medical practice will be analyzed. Measures for the prevention of recurrences will be discussed and a program for making these measures as effective as possible will be outlined.

10:30 A.M.—Roentgen Manifestations in Gastric and Duodenal Lesions—*Ray A. Carter, M.D. and J. E. Vickers, M.D., Los Angeles.*

Paper No. 19. A discussion of the roentgen manifestations of gastric lesions, duodenal and lower esophageal, considering them particularly from the viewpoint of lesions which are not readily distinctive of origin on roentgen evidence alone.

10:50 A.M.—Vagotomy in the Treatment of Peptic Ulcer—*John C. Jones, M.D., Los Angeles.*

Paper No. 20. The indications and contraindications for Simple Vagotomy in the various types of gastric and duodenal ulcers will be discussed, along with the advantages and disadvantages of the abdominal and thoracic approaches for vagotomy.

11:20 A.M.—Interpretation of Gastric Symptoms—*Arthur M. Hoffman, M.D., Los Angeles.*

Paper No. 21. It is well recognized that indigestion and gastric distress do not necessarily mean disease of the stomach. The anatomical overlapping of nervous impulses from contiguous organs—and the reflex gastric effects from distant organs—provides the clinician with a constant challenge as to the actual cause of gastric symptoms. A resume of the problems encountered by the practitioner is presented.

11:40 A.M.—Discussion. (Questions in writing to be passed up to the Moderator.)

Thursday, May 1. 2:00 P.M. Ball Room

Joint Meeting with California Heart Association

Francis L. Chamberlain, M.D., and
John K. Lewis, M.D., presiding

(Note: Time allotted to each of the following papers: 10 minutes; discussion 5 minutes.)

2:00 P.M.—Election of Officers, California Heart Association.

2:10 P.M.—Origin and Propagation of Cardiac Murmurs—*William J. Kerr, M.D., San Francisco.*

Paper No. 22.

2:25 P.M.—The Coronary Arteries in the Newborn and Childhood—*Arthur R. Lack, M.D., Los Angeles.*

Paper No. 23.

2:40 P.M.—Myocardial Infarction and Heart Failure—*Arthur Selzer, M.D., San Francisco.*

Paper No. 24.

2:55 P.M.—Standards for the Diagnosis of Activity and Inactivity in the Rheumatic State—*Harold Rosenblum, M.D., San Francisco.*

Paper No. 25.

3:10 P.M.—Familial Incidence of Rheumatic Fever—*Richard S. Cosby, M.D., Pasadena.*

Paper No. 26.

3:25 P.M.—The Roentgenologic Diagnosis of Syphilitic Cardiovascular Disease—*M. C. Thorner, M.D., and R. A. Carter, M.D., Los Angeles.*

Paper No. 27.

3:40 P.M.—Treatment of Cardiovascular Syphilis—*Olov A. Blomquist, M.D., Los Angeles.*

Paper No. 28.

3:55 P.M.—Recess.

4:05 P.M.—Hypersensitivity, the Common Denominator of the Collagenous Diseases—*Edward R. Evans, M.D., Pasadena.*

Paper No. 29.

4:20 P.M.—Influence of Mercurial Diuretics on Sodium Excretion—*Donald E. Griggs, M.D., and Varner Johns, M.D., Los Angeles.*

Paper No. 30.

4:35 P.M.—Peripheral Venous Pressure Studies in Some Hypotensive States—*Jack A. Scheinkoff, M.D., Sherman Oaks.*

Paper No. 31.

4:50 P.M.—Orthostatic Hypotension and Orthostatic Tachacardia—*Anton Yuskis, M.D., San Diego.*

Paper No. 32.

Friday, May 2. 9:30 A.M. Conference Room 2

9:30 A.M.—Business Meeting and Election of Officers.

SYMPOSIUM DISCUSSION ON "WHAT'S NEW"

(Time allotted to each paper: 10 minutes)

9:35 A.M.—What's New in Cardiovascular Disease—*William Paul Thompson, M.D., Los Angeles.*

Paper No. 33.

9:45 A.M.—What's New in Tropical Medicine—*Alfred C. Reed, M.D., San Francisco.*

Paper No. 34.

9:55 A.M.—What's New in Syphilis—*Charles W. Barnett, M.D., San Francisco.*

Paper No. 35.

10:05 A.M.—What's New in Infectious Diseases—*Hobart A. Reimann, M.D., Philadelphia, Pennsylvania.*

Paper No. 36.

10:15 A.M.—What's New in Pulmonary Diseases—*Reginald H. Smart, M.D., Los Angeles.*
Paper No. 37.

10:25 A.M.—What's New in Gastro-Enterology—*Albert M. Snell, M.D., Rochester, Minnesota.*
Paper No. 38.

10:35 A.M.—Recess.

10:45 A.M.—What's New in Neoplastic Disease—*A. W. Oughterson, M.D., New York City.*
Paper No. 39.

10:55 A.M.—What's New in Endocrinology—*Paul Starr, M.D., Pasadena.*
Paper No. 40.

11:05 A.M.—What's New in Allergy—*George Piness, M.D., Los Angeles.*
Paper No. 41.

11:15 A.M.—What's New in Hematology—*Gurth Carpenter, M.D., Beverly Hills.*
Paper No. 42.

11:25 A.M.—What's New in Peripheral Vascular Disease—*Norman Freeman, M.D. San Francisco.*
Paper No. 43.

11:35 A.M.—Question and Answer Period.
Questions must be submitted in writing and directed to the particular discussant. Monitors will collect such questions during the meeting.

Friday, May 2. 2:00 P.M. Ball Room.

GENERAL MEETING

For Program, see Second General Meeting

Saturday, May 3. 9:30 A.M. Ball Room

Joint Meeting with Sections on General Practice and Urology

For Program, see Section on General Practice

H. BRODIE STEPHENS
Chairman, General Surgery

A. MORSE BOWLES
Secretary, General Surgery

SECTION ON GENERAL SURGERY

H. Brodie Stephens, M.D., San Francisco, *Chairman*
A. Morse Bowles, M.D., Santa Rosa, *Secretary*
Conrad J. Baumgartner, M.D., *Assistant Secretary*

Thursday, May 1. 9:30 A.M. Ball Room

Joint Meeting with Sections on General Medicine, General Practice, Radiology, and Neuropsychiatry

For Program, see Section on General Medicine

Thursday, May 1. 2:00 P.M. Music Room

Joint Meeting with Sections on Industrial Medicine and Surgery, and Neuropsychiatry

2:00 P.M.—Chairman's Address: The Blalock Operation for Congenital Pulmonary Stenosis—*H. Brodie Stephens, M.D., San Francisco.*
Paper No. 44. This report will summarize the results obtained in approximately twenty patients who have undergone operations because of suspected congenital pulmonary stenosis. Diodrast cardiograms constitute an important aid in diagnosis. The technique of the operation has changed little from Blalock's original description. The remarkable improvement that occurs in some of these patients is extremely gratifying.

2:20 P.M.—Surgical Treatment of Mixed Cell Tumors of the Parotid—*Edwin G. Clausen, M.D., Oakland. (Paper written jointly by Edwin G. Clausen, M.D. and Bruce Henley, M.D.)*
Paper No. 45. The high recurrence rate following simple excision of mixed cell tumors of the parotid gland indicates that a more radical procedure is necessary than has been generally employed in the past. Cases at the University of California Hospital for the past twenty years have been reviewed.

2:40 P.M.—Mesenteric Vascular Occlusion—*Albert H. Newton, M.D., Yreka.*
Paper No. 46. The occurance of mesenteric vascular occlusion is infrequent enough (573 cases reported up to 1946, with 36 cases successfully resected), to warrant a report of eight cases operated upon, and a pertinent literary review of the subject. Case reports with end results over a period of thirteen years are presented.

3:00 P.M.—Recess.

SYMPOSIUM ON BACK PAIN

Chairman of Panel: Frederick C. Bost, M. D., San Francisco

3:10 P.M.—Back Pain from the Orthopedic Standpoint—*Hugh T. Jones, M.D., Los Angeles.*
Paper No. 47. The study of back pain from the

orthopedic standpoint requires careful study by a man who is primarily a doctor of medicine and secondly an orthopedist. The fundamentals of history taking and examination must be supplemented by special orthopedic tests and observations in order to avoid costly mistakes in differential diagnosis and indications for treatment.

3:30 P.M.—Report on Post-Operative Complications and Morbidity in the Surgical Treatment of Ruptured Intervertebral Disc—*Rupert Raney, M.D., Los Angeles. (Paper written jointly by speaker and Aidan A. Raney, M.D., Los Angeles.)*

Paper No. 48. A report on post-operative complications and morbidity in the surgical treatment of the ruptured intervertebral disc. The length of hospitalization and man days lost from occupation have been reviewed and the results classified.

3:50 P.M.—Back Pain—Urological Aspect—*O. W. Butler, M.D., Los Angeles.*

Paper No. 49. Brief mention is made of the various diseases of the uro-genital tract which may have a bearing on low back pain. A few brief significant cases are reported.

4:10 P.M.—Low Back Pain and Its Management by the General Surgeon—*Edmond Dana Butler, M.D., San Francisco.*

Paper No. 50. This paper discusses the essential points in the history and physical examination of the low back patient. The anomalies and differential diagnosis by x-ray films will be briefly listed (showing x-ray projection slides if possible). The conservative office and hospital treatment will be briefly discussed.

4:30 P.M.—Back Pain from the Gynecological Standpoint—*Earl B. King, M.D., San Francisco.*

Paper No. 51. Back pain is a frequent complaint of gynecological patients. An attempt will be made to point out the implications of this symptom, and to correlate it with the clinical findings on these patients.

4:50 P.M.—General Discussion.

Questions, in writing, to be passed up to the moderator, who will inspect the same and distribute to members of the panel.

Friday, May 2. 9:30 A.M. Ball Room

Joint Meeting with Section on Anesthesiology, Radiology, General Practice, and Pathology

9:30 A.M.—Curare is a Safe Adjuvant to Light General Anesthesia—*John B. Dillon, M.D., Los Angeles.*

Paper No. 52. Curare is a safe adjuvant to light general anesthesia to produce adequate surgical relaxation. There is a certain amount of synergism between curare and general anesthetic agents, particularly ether. Curare should not be used by those unable to provide adequate ventilation of the patient under all circumstances.

9:50 A.M.—Wound Healing and Wound Disruption *E. J. Joergenson, M.D., Glendale.*

Paper No. 53. The paper is a review of faulty wound healing, its recognition and prevention, and its management once disruption occurs. Emphasis must be placed on prevention and the recognition of this complication in its early phases if this high mortality rate is to be reduced.

10:10 A.M.—Recurrent Inguinal Hernia — *Sumner Everingham, M.D., Oakland.*

Paper No. 54. Recurrent inguinal hernia occurs because of lack of the right operation properly done or lack of fundamental wound repair on part of patient. Factors considered on part of patient, those on part of surgeon. Technical errors would seem most liable, for if factors at recurrence were recognized at primary procedure, first operation would be adequate.

10:30 A.M.—Business Meeting and Election of Officers.

PANEL DISCUSSION ON BREAST TUMORS

Chairman of Panel: Alson R. Kilgore, M.D., San Francisco

10:50 A.M.—Management of Bleeding from the Nipple—*Ian MacDonald, M.D., Los Angeles.*

Paper No. 55. The significance of bleeding nipples before and after the menopause, in terms of hyperplastic and neoplastic processes, is emphasized. The surgical management, stressing conservative treatment in the proven absence of carcinoma, is important.

11:05 A.M.—The Painful Breast—*James M. Neil, M.D., Oakland.*

Paper No. 56. Painful breast clinical syndromes are recognized, interpretation rests upon clinical correlation. Pain is of greater importance psychologically than diagnostically. Mammary self examination and pain absence in early malignancy should be stressed.

11:20 A.M.—Irradiation Therapy in Treatment of Breast Cancer—*Lowell S. Goin, M.D., Los Angeles.*

Paper No. 57. Irradiation therapy in the management of carcinoma of the breast. When shall radiation therapy be employed, when shall it be omitted entirely, which cases are suited only for surgery and which only for radiation therapy and in what cases shall the two methods be combined? The role of castration is discussed.

11:35 A.M.—Pathology of the Breast—*T. S. Kimball, M.D., Glendale.*

Paper No. 58. In lesions of the breast it is quite imperative that the surgeon and pathologist work as a team. More so than in any other possible malignant process of the body, with the possible exception of the uterus. Early carcinoma diagnosed at the time of operation has a much better chance for five-year cure.

12:05 P.M.—Inoperable Cancer of the Breast; Its Management—*Eric Reynolds, M.D., Oakland.*

Paper No. 59. Both androgens and estrogens have been used in the treatment of cancer of the breast. A delineation of some of these results is included. Care of the inoperable and the metastatic case is an important nursing and palliative challenge. Observing a tendency to be niggardly about the use of opiates in hopeless cases, a plea is made to be generous in the alleviation of suffering from this disease.

12:20 P.M.—Diagnosis of Early Breast Cancer—*William D. McCarthy, M.D., Oakland.*

Paper No. 60. Early diagnosis breast cancer on following importance of examination axilla; slight cephalad elevation nipple; slight infraclavicular edema; aspiration biopsy; trans illumination and accurate Low-Beer method for detecting and localizing lesion with intravenous radio-active phosphorus.

12:40 P.M.—General Discussion.

Questions in writing, to be passed up to the Moderator, who will inspect the same and distribute to members of the panel.

ERIC A. ROYSTON
Chairman, General Practice

STANLEY R. TRUMAN
Secretary, General Practice

SECTION ON GENERAL PRACTICE

Eric A. Royston, M.D., Los Angeles, *Chairman*
Stanley R. Truman, M.D., Oakland, *Secretary*

Wednesday, April 30. 2:00 P.M. Conference Room 8
Joint Meeting with Section on Anesthesiology

2:00 P.M.—Surgery of the Aged—*J. Norton Nichols, M.D., Los Angeles.*

Paper No. 61. A discussion of the elderly patient as a surgical risk, with some statistical information on the increased hazards due to age. Special preoperative preparation and anesthesia are included as well as certain standard surgical procedure which must be modified to suit the patient's diminished resistance.

2:20 P.M.—Discussion.

2:30 P.M.—Geriatric Anesthesia—*James Cadranel, M.D., Los Angeles.*

Paper No. 62. Individualization of premedication, anesthetic agent, dose and method is an essential requirement. Careful regulation of these factors reduces the risk usually ascribed to age. A statistical study of 1,000 cases and recommendations are presented.

2:50 P.M.—Discussion by *S. W. Sensiba, M.D., Santa Monica.*

3:00 P.M.—Proctology for the General Practitioner —*Robert Scarborough, M.D., San Francisco.*

Paper No. 63. Proper treatment of diseases of the anus, rectum and colon is dependent upon the correct interpretation of certain symptoms common to a wide variety of causes. This cannot be accomplished without adequate examination. The basic armamentarium for such examination consists of a rubber glove, lubricating jelly, a flexible probe, an anoscope, and a proctoscope, with facilities available for barium enema examination. A concise summary will be given of the differential diagnosis and treatment of the causes of the following symptoms: external peri-anal swellings, anal protrusions, pain, discharge, bleeding, disturbances of bowel habits, certain digestive symptoms and pruritus ani.

3:20 P.M.—Discussion.

3:30 P.M.—Surgery of the Diseased Ovary—*J. Ludwig Emge, M.D., San Francisco.*

Paper No. 64. The interpretation of pain in the ovarian regions and palpable physical changes of the ovaries are discussed on the basis of neuroanatomy and physiology of the generative organs. Particular attention is given to the evaluation of enlarged and cystic ovaries in relation to retention, suspension and transplantation of these organs. Surgical problems involving endometriosis and inflammatory processes, and the preservation of ovaries are discussed briefly. Surgical and roentgenologic treatment of neoplastic disease are discussed on the basis of personal experience with material collected over thirty years in the service of the Stanford Women's Clinic.

3:50 P.M.—Discussion.

4:00 P.M.—Chairman's Address—The Section on General Practice: Its Problems, Its Goals, Its Responsibilities—*Eric A. Royston, M.D., Los Angeles.*

Paper No. 65. Rightly or wrongly, the General Practice group feels its members have been and are still being discriminated against both in the metropolitan hospitals and in general administrative medicine. Accordingly, the Section feels it should have adequate representation on each hospital staff and on the Council of each county medical society. It recognizes its responsibilities to the community, to the hospital, and to medicine at large. The General Practice group is probably the last bulwark between medicine as we know it today, and the prospect of socialized medicine which is dancing on our horizon.

4:20 P.M.—Discussion.

4:30 P.M.—Business Meeting and Election of Officers.

Thursday, May 1. 9:30 A.M. Ball Room
Joint Meeting with Sections on General Medicine, General Surgery, and Radiology.
For Program, see Section on General Medicine

Friday, May 2. 9:30 A.M. Ball Room
Joint Meeting with Sections on General Surgery, Radiology, Pathology and Bacteriology, and Anesthesiology
For Program, see Section on General Surgery

Saturday, May 3. 9:30 A.M. Ball Room

Joint Meeting with Sections on General Medicine and Urology

SYMPOSIUM ON ARTHRITIS

9:30 A.M.—X-ray Diagnosis and Therapy in Arthritis—*Merle F. Godfrey, M.D., Glendale.*

Paper No. 66. (1) Accurate diagnosis can best be arrived at through radiographs of the hands. (2) X-ray therapy in the arthritides is two types: a. Radiation to much inflamed joints; b. General body radiation after the manner of Gilbert Scott and Gunnar Kahlstrom and others.

9:50 A.M.—Gold Therapy in Rheumatoid Arthritis —*Hans Waine, M.D., San Francisco.*

Paper No. 67. Diagnosis of Rheumatoid Disease. The present concept of rheumatoid arthritis is that of a constitutional and systemic disease. Recognition of the early manifestations is important for good therapeutic results. The clinical characteristics of early rheumatoid disease, some of its nonarticular expressions and the use of gold salts are discussed.

10:10 A.M.—Vaccine Therapy in Treatment of Arthritis—*Raymond L. Jeffery, M.D., Los Angeles.*

Paper No. 68. Infection, although very important, is only part of arthritic syndrome; hence, vaccine constitutes only an arm of the management. Successful use of vaccines is entirely possible, and depends upon several things. First, a proper physiological diagnosis. Vaccine therapy must be accompanied by adequate physiological treatment. The vaccine must be as specific as possible. And the dosage must be individually adjusted, and properly timed.

10:30 A.M.—The Physical Therapy of Rheumatoid Arthritis—*Fred B. Moor, M.D., Los Angeles.*

Paper No. 69. The physical measures used in the treatment of rheumatoid arthritis are heat, massage, and exercise. The application of heat may be local or general, moist or dry. Heat is usually followed by massage to the muscles adjacent to the involved joints. Although rest of inflamed joints is important, yet every involved joint should be put through the maximum possible range of motion daily.

10:50 A.M.—Diet in Atrophic Arthritis—*Albert G. Bower, M.D., Pasadena.*

Paper No. 70. Fletcher's x-ray studies at Toronto showed a marked visceroptotic colon with manifestations varying from atony to spasticity. Further, that under a low carbohydrate, maintenance protein, high fat diet with an unusually high vitamin B-complex component, the bowel gradually resumed a more nearly normal position and function, and concurrently the arthritic symptoms improved.

11:10 A.M.—Principles and Methods of Treatment of the Chronic Arthritides—*Bernard L. Wyatt, M.D., Los Angeles.*

Paper No. 71. The principles of treatment of the chronic arthritides are: a. The patient must assume personal obligations and responsibilities in the "partnership"; b. Composite programs of therapy are different for the different clinical types; c. Every patient's treatment must be based upon individual indications and requirements. Treatment measures *of proved and unproved value* will be presented under these captions.

11:30 A.M.—The Treatment of Deformities in Chronic Arthritis—*John C. Wilson, M.D., Los Angeles.*

Paper No. 72. Any discussion of the treatment of deformities in chronic arthritis must have as its first consideration the methods for the prevention of such deformities. The use of splints, traction, stretching and other forms of physical therapy together with the surgical management of these conditions will be discussed. Some of the pitfalls encountered in the surgical treatment of deformities due to chronic arthritis will be mentioned. The position of choice for fusion of joints will also be briefly discussed.

SYMPOSIUM ON URINARY TRACT INFECTIONS

11:50 A.M.—Medicine—*Charles A. Noble, M.D., San Francisco.*

Paper No. 73.

12:10 P.M.—Urology—*Sidney Olsen, M.D., San Francisco.*

Paper No. 74.

12:30 P.M.—Discussion.

JOHN A. STILES
Chairman, Anesthesiology

IDA HEISSIG
Secretary, Anesthesiology

SECTION ON ANESTHESIOLOGY

John A. Stiles, M.D., San Francisco, *Chairman*
Ida Heissig, M.D., Altadena, *Secretary*

Wednesday, April 30. 2:00 P.M. Conference Room 8

Joint Meeting with Section on General Practice

For Program, see Section on General Practice

2:30 P.M.—Recess to Room 5 for Second Half of Program.

2:40 P.M.—Chairman's Address: Two Case Reports —*John A. Stiles, M.D., San Francisco.*

Paper No. 75. (1) Rupture of a bronchus immediately following a pneumonectomy with respiratory exchange limited and finally stopping due to increased intrathoracic pressure, relieved first by reintubation and then by aspiration and closed drainage of the chest.

(2) A 62-year-old man with hiccups of 40 days' duration who was treated with CO_2 inhalations, attempted phrenic block, intocostrin and finally large doses of intramuscular sodium amytal.

3:00 P.M.—Anesthesia in Thoracic Surgery—*L. M. Taylor, M.D., San Bernardino.*

Paper No. 76. Consideration of the physiological alterations in the surgical pneumothorax. Anesthesia experiences in a thoracic surgical center in the U. S. Army. Methods of administering anesthetics in over 200 major thoracic surgical cases including resections in infants.

3:20 P.M.—Discussion by *Thomas B. Wiper, M.D., Belmont.*

3:30 P.M.—A Preliminary Report on Anesthesia for the Fenestration Operation—*William G. Meals, M.D., Los Angeles.*

Paper No. 77. A review of 300 cases for the Fenestration Operation is made. This includes premedication, type of anesthesia, procedure for the anesthesia, results, and a study of the complications thereof.

3:50 P.M.—Discussion by *Howard P. House, M.D., Los Angeles.*

Thursday, May 1. 2:00 P.M. Conference Room 4

Joint Meeting with Section of Obstetrics and Gynecology

For Program, see Section on Obstetrics and Gynecology

2:30 P.M.—Recess to Room 6 for Second Half of Program.

2:40 P.M.—Further Experience with Pontocaine-Dextrose-Ephedrine for Spinal Anesthesia—*Forrest E. Leffingwell, M.D., and Arthur J. Martinson, M.D., Los Angeles.*

Paper No. 78. Introductory discussion of the work done by the original and subsequent investigators and a presentation of the authors' experience with this procedure, including statistics covering their series up to date, with a discussion of the findings and conclusions drawn therefrom as to the value of the technique.

3:00 P.M.—Discussion by *C. F. McCuskey, M.D., Los Angeles.*

3:10 P.M.—Low Dosage with Continuous Spinal Anesthesia—*Charles C. Wycoff, M.D., San Francisco.*

Paper No. 79. A dosage as low as 10 mg. increments of Intracaine may be used to attain and maintain relaxation and anesthesia for abdominal surgery with the ureteral catheter continuous spinal. Pontocaine in 1 mg. doses may also be used. Certain patients require less agent, and others require more.

3:30 P.M.—Discussion by *Ernest Warnock, M.D., Los Angeles.*

3:40 P.M.—Business Meeting and Election of Officers.

Friday, May 2. 9:30 A.M. Ballroom

Joint Meeting with General Surgery

For Program, see Section on General Surgery

FRANCES TORREY
Chairman,
Dermatology and Syphilology

E. V. ALLINGTON
Secretary,
Dermatology and Syphilology

SECTION ON DERMATOLOGY AND SYPHILOLOGY

Frances Torrey, M.D., San Francisco, *Chairman*
Hiram D. Newton, M.D., San Diego, *Vice-Chairman*
E. V. Allington, M.D., Oakland, *Secretary*

Thursday, May 1. 9:30 A.M. Conference Room 9

9:30 A.M.—Lymphocytoma — *Walter F. Schwartz, M.D., Pasadena.*

Paper No. 80. Lymphocytoma is a rare lymphoid tumor of the skin. It has not been previously described in American dermatological literature. A case is reported. The usual location and clinical appearance of the lesions are fairly characteristic, but a definite diagnosis depends on histologic study.

9:50 A.M.—Discussion by *N. P. Anderson, M.D., Los Angeles.*

10:00 A.M.—The Differential Diagnosis of Some of the Benign Tumors of the Skin—*Arne E. Ingels, M.D., San Francisco.*

Paper No. 81. The clinical and histopathological features of von Recklinghausen's disease, sebaceous adenomas, sweat gland tumors, neuromas, senile warts, and other tumors are described. The possible relationship between von Recklinghausen's disease and tuberous sclerosis is discussed. Curative procedures are outlined.

10:30 A.M.—Discussion by *Clement E. Counter, M.D., Long Beach, and Edward J. Ringrose, M.D., Berkeley.*

10:40 A.M.—The Precancerous Dermatoses with Special Reference to Their Histologic Diagnosis—*Walter R. Nickel, M.D., San Diego.*

Paper No. 82. A consideration of the histologic changes in the various layers of the skin in the precancerous dermatoses with special reference to benign and malignant dyskeratotic phenomena. Clinical and micro-photographs will be shown.

11:10 A.M.—Discussion by *Ervin H. Epstein, M.D., Oakland, and Molleurus Couperus, M.D., Los Angeles.*

11:20 A.M.—The Treatment of Epitheliomas—A Critical Review of Methods Employed During the Past Twenty-five Years—*W. W. Duemling, M.D., San Diego.*

Paper No. 83. Various methods, from Sherwell's curet and caustic to the present day topical application of radioactive phosphorus, are reviewed. Emphasis is given to the need of first selecting the proper therapeutic agent to meet a given situation and then applying the chosen agent in a skillful and adequate manner.

11:50 A.M.—Discussion by *H. J. Templeton, M.D., Oakland, and Hiram Newton, M.D., San Diego.*

12:00 Noon—Chairman's Address: The Visible Tumor Clinic at the University of California Medical School—*Francis Torrey, M.D., San Francisco.*

Paper No. 84. History of the development of the Visible Tumor Clinic at the University of California Medical Center. Its organization and comparison with similar clinics in other medical schools. Discussion of the value of the organization—for interdepartmental correlation in the diagnosis and treatment of skin malignancy, for postgraduate teaching and as a consultation clinic for the benefit of patients and referring physicians.

12:20 A.M.—Discussion by *A. W. Oughterson, M.D., New York City.*

Thursday, May 1. 2:00 P.M. Conference Room 9

2:00 P.M.—Treatment of Superficial Fungus Infections in Routine Dermatologic Practice—*Rees B. Rees, M.D., San Francisco.*

Paper No. 85. An evaluation of methods used and results obtained in the treatment of dermatophytosis of the feet, groin, body, and tinea capitis by the Dermatology Staff of the University of California. Higher fatty acids and other currently popular agents will receive attention.

2:25 P.M.—Discussion by *J. Walter Wilson, M.D., Los Angeles, and Robert A. Stewart, M.D., Berkeley.*

2:35 P.M.—Benadryl and Pyribenzamine in the Treatment of Skin Diseases—*Grant Morrow, M.D., San Francisco.*

Paper No. 86. Benadryl and pyribenzamine are new synthetic anti-histamine drugs. They have been used in the treatment of urticaria, erythema multiforme, erythema nodosum and pruritus from various causes. Results are encouraging. The incidence of toxic reactions, results and differences between the two drugs will be discussed.

3:00 P.M.—Discussion by *Katherine McEachern, M.D., Los Angeles, and James R. Drake, M.D., San Francisco.*

3:10 P.M.—The Use of Vitamin A in the Treat-

ment of Skin Diseases—*Frances M. Keddie, M.D., San Francisco.*

Paper No. 87. This paper is concerned with the problem of utilization of Vitamin A and the problem of dosage rather than with its clinical application. A case of pityriasis rubra pilaris which responded to treatment with Vitamin A given parenterally but not to oral administration will be discussed.

3:35 P.M.—Discussion by *Maximilian E. Obermayer, M.D., Los Angeles, and Charles W. McNitt, M.D., Reno, Nevada.*

3:45 P.M.—Some Aspects of Dermatological Treatment with Vitamin B Complex—*Harry Levitt, M.D., Los Angeles.*

Paper No. 88. This paper deals with the role of Vitamin B complex in the pathogenesis and treatment of certain cutaneous disorders, especially as it influences carbohydrate metabolism and in its relation to cutaneous infection. Emphasis is placed on the use and action of the various fractions as a group rather than individually.

4:10 P.M.—Discussion by *Charles A. Shumate, M.D., San Francisco, and Julius R. Scholtz, M.D., Los Angeles.*

4:20 P.M.—The External Use of Carbitol Solvent—*Willard M. Meininger, M.D., San Francisco.*

Paper No. 89. Carbitol solvent (diethylene glycol monoethyl ether) is an ingredient of many cosmetics. Toxicity levels have been demonstrated in experimental animals following its ingestion, injection, and topical application. This compound was prescribed for external use in several common formulas to determine its utility and possible toxic effects in man.

4:45 P.M.—Discussion by *Ben A. Newman, M.D., Los Angeles, and M. T.-R. Maynard, M.D., San Jose.*

Friday, May 2. 9:30 A.M. Conference Room 9

9:30 A.M.—The Intensive Ambulatory Treatment of Early Syphilis with Penicillin, Arsenicals, and Bismuth—*Paul Fasal, M.D., San Francisco.*

Paper No. 90. Ten injections of calcium penicillin in oil and wax combined with arsenicals and bismuth have apparently given satisfactory results. Reactions resulting therefrom are discussed and suggestions are presented for reduction of their incidence. The socio-economic advantages of this treatment are presented.

9:55 A.M.—Discussion by *Thomas H. Sternberg, M.D., Los Angeles, and Richard A. Koch, M.D., San Francisco.*

10:05 A.M.—Reinfection in Syphilis—*Norman N. Epstein, M.D., San Francisco.*

Paper No. 91. The criteria for indisputable reinfection in syphilis are so exacting as to make it almost impossible to meet these requirements clinically. There is a growing tendency to diminish the strictness of these criteria. Two cases are reported in which reinfection undoubtedly occurred. The relation between reinfection, superinfection, and relapse is discussed.

10:30 A.M.—Discussion by *Kenneth L. Stout, M.D., Los Angeles, and David Frost, M.D., Oakland.*

10:40 A.M.—Syphilis in Pregnancy—*Charles W. Barnett, M.D., San Francisco, and John Marion Read, M.D., San Francisco.*

Paper No. 92. A review of a series of cases from the Stanford Clinics leads to the conclusion that syphilis is not as hazardous in pregnancy as it is reputed to be. The incidence of prenatal syphilis is relatively low if positive cord bloods are not considered diagnostic of syphilis.

11:05 A.M.—Discussion by *A. Fletcher Hall, M.D., Santa Monica, and Norman N. Epstein, M.D., San Francisco.*

11:15 A.M.—Management of Neurosyphilis—*Thomas H. Sternberg, M.D., Los Angeles, Paul Le Van, M.D., Los Angeles, and R. Raymond Allington, M.D., Los Angeles.*

Paper No. 93. This paper deals with a group of patients with neurosyphilis treated with penicillin alone and penicillin in combination with malaria. The results are evaluated and certain conclusions presented. The current literature on this subject is reviewed.

11:40 A.M.—Discussion by *George V. Kulchar, M.D., San Francisco, and Julius R. Scholtz, M.D., Los Angeles.*

11:50 A.M.—Business Meeting and Election of Officers.

PIERRE VIOLE
Chairman,
Eye, Ear, Nose and Throat

DOHRMANN K. PISCHEL
Secretary,
Eye, Ear, Nose and Throat

SECTION ON EYE, EAR, NOSE AND THROAT

Pierre Viole, M.D., Los Angeles, *Chairman*
George L. Kilgore, M.D., San Diego, *Vice-Chairman*
Dohrmann K. Pischel, M.D., San Francisco, *Secretary*

Thursday, May 1. 2:00 P.M. Conference Room 2

2:00 P.M.—Otomycosis; Therapy of Proved Efficacy—*Ben Bryant, M.D., Los Angeles.*

Paper No. 94. The fallacy of former methods of treatment is considered to explain the so-called recurrences in cases of otomycosis. Therapy is outlined as directed at two distinct phases: (1) the secondary, acute, external otitis and its complications; (2) the underlying mycosis. Prescriptions for the medications used are given and certain essential points pertaining to their use are emphasized. 4,610 consecutive cases of otomycosis are reported, treated by the method outlined and without recurrence. In conclusion, a series of nine rules is listed to govern the treatment of otomycosis and its complications.

2:20 P.M.—Discussion.

2:30 P.M.—Current Trends in the Technique of Tonsillectomy—*Durwin Hall Brownell, M.D., San Diego.*

Paper No. 95. After outlining his technique for removal of the tonsils and adenoids and a resume of the literature on tonsillectomy, the author analyzes the data obtained from replies to a questionnaire sent to the members of the American Laryngological, Rhinological and Otological Society.

2:50 P.M.—Discussion.

3:00 P.M.—Principles of Aural Rehabilitation—*Grant Fairbanks, Ph.D., Los Angeles. (By invitation).*

Paper No. 96. Description of modern techniques in aural rehabilitation. Special attention to hearing aid selection and supervision, auditory training, lip reading instruction, speech correction and psychological counseling. Emphasis on integration of the medical, surgical, acoustical, educational and psychological phases.

3:20 P.M.—Discussion.

3:30 P.M.—The Treatment of Acute Neck Infections—*Colby Hall, M.D., Los Angeles.*

Paper No. 97. In dealing with acute neck infections the immediate condition of the patient is of prime importance. It is imperative that the patient's general condition be considered while we are debating as to the exact diagnosis. The differential diagnosis and the applied anatomy of the pharyngomaxillary space, the masticator space, Ludwig's, and other suprahyoid areas are important. One must remember that a pathological diagnosis must be considered if rational therapy is to be applied to suppurative, non-suppurative, and/or vascular involvement. Thrombophlebitis, arterial erosion, tetanus, and diphtheria are among the diagnoses which we must keep in mind. The practical application of our anatomical knowledge is essential in the clinical management of acute neck infections.

3:50 P.M.—Discussion.

4:00 P.M.—Condition Response in Children—*Russell Decker, M.D., Pasadena.*

Paper No. 98. This is a film showing the reaction of children to sound vibrations. First a normal hearing child of one year is shown and the normal response to certain sounds. Then a one year old child of suspected deafness is shown and responses to the same sounds. Children with known deafness from one to twelve years of age are shown being tested for various degrees of hearing loss.

4:20 P.M.—Discussion.

4:30 P.M.—Motion pictures on topics of interest to the specialty.

Friday, May 2. 2:00 P.M. Conference Room 2

2:00 P.M.—Business Meeting and Election of Officers.

2:05 P.M.—Psychosomatics in Eye, Ear, Nose and Throat Practice—*Kenneth Brandenburg, M.D., Long Beach.*

Paper No. 99. Several case histories will be given showing the part emotional conflicts play in the causation of symptoms complained of by eye, ear, nose, and throat patients.

2:25 P.M.—Discussion.

2:35 P.M.—The Scleral Resection Operation for Retinal Detachment—*William E. Borley, M.D., San Francisco.*

Paper No. 100. This operation was first proposed by Leopold Muller in 1903 for the treatment of retinal detachment in high myopia. It was his belief that detachment in highly myopic eyes resulted from a transudation under the retina due to a stretching of the choroid. The operation as done at

the present time is a modification of the original procedure and in the author's experience is indicated either alone or in combination with diathermy in cases of detachment with large disinsertion following trauma, and in cases of detachment following congenital retinal septa. It has also proved useful in cases of retinal detachment in aphakic eyes.

2:55 P.M.—Discussion.

3:05 P.M.—The Argyll-Robertson Pupil as an Isolated Neurological Sign in Central Nervous System Syphilis—*George S. Lachman, M.D., San Francisco.*

Paper No. 101. The true Argyll-Robertson pupil is an infallible sign of central nervous system syphilis. In standard text books of neurology and in a considerable number of case reports in the literature the Argyll-Robertson phenomenon is described in conditions other than syhpilis, e.g., tumors of the mid-brain. These are not true Argyll-Robertson pupils because the criteria comprising the sign are not satisfied. The various theories as to the location of the lesion are evaluated. From the records of the medical out-patient department of Stanford Hospital, the Argyll-Robertson pupil was found to be the only neurological evidence of central nervous system syphilis in 32 cases.

3:25 P.M.—Discussion.

3:35 P.M.—Acute Central Ulcers of the Cornea—*Phillips Thygeson, M.D., San Jose.*

Paper No. 102. In a study of 50 central ulcers of the cornea the causative agents were found to be limited to five bacteria, i.e., pneumococcus, beta hemolytic streptococcus, pyocyaneus bacillus (pseudomonas aeruginosa), Friedlander's bacillus (Klevsiella pneumoniae), and the Diplobacillus of Petit. In this report the clinical course of each type is outlined and the results of therapy, particularly with chemotherapeutic and antibiotic agents, is discussed.

3:55 P.M.—Discussion.

4:05 P.M.—Intraocular Foreign Bodies in Naval Personnel—*Hugo Lucic, M.D., San Diego.*

Paper No. 103. Within a period of 3½ years of the recent war, approximately 95 cases of intraocular foreign bodies were treated at one of the Naval Base Hospitals on the Pacific Coast. The records of 68 patients were analyzed. Forty of these 68 men were injured in combat and the remaining 28 in the course of military training or work, usually in the vicinity of the hospital. Of those injured in action, 35 harbored particles which were presumed to be non-magnetic, and the other 5 had magnetic particles. Of the 28 men who were injured at work or in the course of training, 21 had magnetic and 7 non-magnetic particles.

A discussion on the diagnosis of intraocular foreign bodies, their localization and treatment is illustrated by individual cases and by lantern slides. It is remarkable that not a single case of sympathetic ophthalmia occurred among hundreds of penetrating ocular injuries which were seen throughout the war at one of the largest Naval Hospitals.

4:25 P.M.—Discussion.

4:35 P.M.—Motion pictures on topics of interest to the specialty.

SECTION ON INDUSTRIAL MEDICINE AND SURGERY

Richard J. Flamson, M.D., Los Angeles, *Chairman*
Keene O. Haldeman, M.D., San Francisco, *Vice-Chairman*
Joseph D. Peluso, M.D., Los Angeles, *Secretary*

RICHARD J. FLAMSON
Chairman,
Industrial Medicine and Surgery

JOSEPH D. PELUSO
Secretary,
Industrial Medicine and Surgery

Thursday, May 1. 2:00 P.M. Music Room
Joint Meeting with Sections on General Surgery and Neuropsychiatry
For Program, see Section on General Surgery

Friday, May 2. 2:00 P.M. Conference Room 8
Joint Meeting with Sections on Neuropsychiatry and Radiology

2:00 P.M.—Radicular Pain in the Upper Limbs—*John B. Doyle, M.D., Los Angeles.*

Paper No. 104. The differential diagnosis of radicular pain in the upper limbs is a problem of importance. It is discussed in some detail with a view to establishing the fundamental etiological factors upon which are predicated suitable treatment.

2:20 P.M.—Discussion.

2:30 P.M.—Chronic Shoulder Pain—*Alonzo J. Neufeld, M.D., Los Angeles.*

Paper No. 105. This discussion is limited to a brief review of the physiology of shoulder function

and the pathology of the common conditions responsible for shoulder pain; namely, acute sprain with or without chronic degenerative disease; chronic myalgia, shoulder capsulitis, and tendonitis with or without calcification. The popular modalities of therapy will be discussed in their relation to the pathology and their influence on disability.

2:50 P.M.—Discussion.

3:00 P.M.—Roentgen Rays in the Diagnosis and Treatment of the Painful Shoulder—*James B. Irwin, M.D., San Diego.*

Paper No. 106. The paper will discuss the causes of the painful shoulder, the role of chronic bursitis in causing shoulder pain, the incidence and location of calcium around the shoulder, and the indications for and the results of x-ray therapy in the various types of shoulder lesions.

3:20 P.M.—Discussion.

3:30 P.M.—Clinical Picture Associated with Rupture of the Intervertebral Disc in the Cervical Region—*O. W. Jones, Jr., M.D., San Francisco.*

Paper No. 107. Several neurological conditions may cause symptoms referrable to the neck and shoulder region. Careful neurological examination to rule out such possibilities as cervical rib, the scalenus anticus syndrome, radicular pain, cord tumor, and rupture of the cervical intervertebral disc should be done in all patients with confusing clinical pictures involving the neck, high back, shoulder, and arm. Differential diagnostic considerations with special reference to the relatively new clinical entity, ruptures of the intervertebral disc in the cervical region, will be discussed.

3:50 P.M.—Discussion by *Edwin B. Boldrey, M.D., San Francisco.*

Saturday, May 3. 9:30 A.M. Conference Room 8

9:30 A.M.—Business Meeting and Election of Officers.

10:00 A.M.—Epiphyseal Disease in Industrial Surgery—*Harold E. Crowe, M.D., Los Angeles.*

Paper No. 108. Epiphyseal disease and industrial surgery are subjects usually thought of as unrelated. This is true where child labor is illegal. However, the osteochondritides of the adolescent years produce physical disabilities of which the worker may be entirely unaware at the time of employment. X-rays will be exhibited of these lesions which, under stress of heavy labor, become symptomatic and must be adjudged as aggravations of pre-existing conditions under the present industrial accident laws.

10:20 A.M.—Discussion.

10:30 A.M.—Partial Excision of Clavicle in Rheumatoid Arthritis—*Frederic W. Ilfield, M.D., Los Angeles.*

Paper No. 109. Partial cleidectomy has been done in six patients with rheumatoid arthritis. All of these patients complained of shoulder pain and limitation of motion. Following operation, there was marked relief of pain and marked increase in shoulder motion. After partial excision of the clavicle, there was an immediate increase in shoulder motion of from 15 to 35 degrees on the operating table while the patient was still under anesthesia. Postoperative shoulder motion, active, increased from 40 to 160 degrees.

10:50 A.M.—Discussion.

11:00 A.M.—The Response of Articular Cartilage to Trauma with Special Reference to the Knee Joint—*Keene O. Haldeman, M.D., and Ralph Soto-Hall, M.D., San Francisco.*

Paper No. 110. Because it is a highly specialized form of connective tissue, articular cartilage lacks regenerative power. The knee joint, due to its complexity and exposed position, is subject to single or oft repeated traumata. The behavior of cartilage in these conditions has been studied clinically and experimentally as an aid to diagnosis and treatment.

11:20 A.M.—Discussion.

11:30 A.M.—Delayed Tetanus Infection—*Joseph D. Peluso, M.D., Los Angeles.*

Paper No. 111. This paper discusses delayed or late tetanus. Three cases will be presented, in which tetanus developed many weeks following the initial injury. In each case, the patient received a prophylactic dose of antitetanus serum. One patient also received penicillin. In spite of the prophylactic doses, all cases developed tetanus; two of them with marked symptoms. All recovered. This paper will also refer to experiences in the Army and Navy in the late war, following the use of toxoid as prophylactic.

11:50 A.M.—Discussion.

ARTHUR R. TIMME
Chairman, Neuropsychiatry

ROBERT B. AIRD
Secretary, Neuropsychiatry

SECTION ON NEUROPSYCHIATRY

Arthur R. Timme, M.D., Los Angeles, *Chairman*
Robert B. Aird, M.D., San Francisco, *Secretary*

Thursday, May 1. 9:30 A.M. Music Room

9:30 A.M.—Intradiploic Epidermoid Tumors—*Leo J. Adelstein, M.D., Los Angeles.*

Paper No. 112. These so-called "pearly tumors" of the skull, while rare, may be associated with head trauma and produce neurologic findings, as well as cosmetic deformity. Report of two cases.

9:50 A.M.—Discussion by *David L. Reeves, M.D., Santa Barbara.*

10:00 A.M.—Electroshock and Other Therapeutic Considerations in Sexual Psychopathy—*George N. Thompson., M.D., Los Angeles.*

Paper No. 113. Treatment of the psychopathic personality presents the most difficult problems met by the psychiatrist. Psychoanalysis is at present the therapy most frequently utilized. Other methods have little to offer. Chemotherapy is unsatisfactory; neurosurgery offers the greatest hope for the future, but at present has not developed efficacious techniques. The shock therapies, particularly convulsive shock therapy, are evaluated, and a series of cases treated by this method is presented. Results of therapy are evaluated.

10:20 A.M.—Discussion by *J. M. Nielsen, M.D., Los Angeles.*

10:30 A.M.—The Suppression of Electric Shock and Electronarcosis by Modification of the Current Level—*Esther Bogen Tietz, M.D., Arcadia, Clarence W. Olsen, M.D., and William R. Rosanoff, M.D., Los Angeles.*

Paper No. 114. A report will be presented of our experience in eliminating the initial and closing contraction during electronarcosis and electric shock by means of rapidly increased and decreased currents. This method eliminates the risk of compression fractures without the use of Curare.

10:50 A.M.—Discussion by *James Solomon, M.D., Compton.*

11:00 A.M.—Facial Pain—*Howard C. Naffziger, M.D., and Edward W. Davis, M.D., San Francisco.*

Paper No. 115. An analysis of the cases of trigeminal neuralgia seen at the University of California Hospital with particular reference to the characteristics of pain in tic douloureus. Comments on atypical pain and postoperative dysesthesias.

11:20 A.M.—Discussion by *Nathan Norcross, M.D., San Francisco.*

11:30 A.M.—Massive Protrusion of the Intervertebral Disc Producing Compression of the Cauda Equina—*Howard A. Black, M.D., Sacramento.*

Paper No. 116. Writings pertaining to this important clinical entity, massive posterior protrusion of the intervertebral disc producing compression of the cauda equina, have been submerged by the recent flood of literature on the more common unilateral disc syndrome implicating a single root. The purpose of this communicating is to report 12 cases illustrating the condition under consideration, and, by analysis of the cases, to indicate features which may aid accurate preoperative diagnosis; and also to stress the importance of prompt recognition and surgical intervention, less incapacitation follow delay in alleviation of the compression of the cauda equina.

11:50 A.M.—Discussion by *O. W. Jones, Jr., M.D., San Francisco.*

Thursday, May 1. 2:00 P.M. Music Room

Joint Meeting with Sections on General Surgery and Industrial Medicine and Surgery

For Program, see Section on General Surgery

Friday, May 2. 9:30 A.M. Conference Room 8

9:30 A.M.—Business Meeting and Election of Officers.

9:45 A.M.—Chairman's Address: The Choreiform Syndrome. Its Significance in Children's Behavior Problems—*Arthur R. Timme, M.D., Los Angeles.*

Paper No. 117. Syndrome is described, which this observer has found to be at the core of probably a majority of school behavior problems. This is an organic syndrome usually overlooked in orthodox Child Guidance procedure or erroneously attributed to purely emotional factors.

10:05 A.M.—The Treatment of Epilepsy with Methylphenylethyl Hydantoin (Mesantoin)—*Robert B. Aird, M.D., San Francisco.*

Paper No. 118. Methylphenylethyl hydantoin (Mesantoin) is chemically related to diphenyl hydantoin (Phenytoin). This new anticonvulsive agent proved of definite value in a high percentage of

patients with convulsive states of the Jacksonian or grand mal types, who were toxic to or could not be controlled by the sodium salt of diphenylhydantoin. Although toxic in a small percentage of patients, it appeared to be as safe as, if not more safe than, phenytoin and should be an important addition to our therapeutic armamentarium in epilepsy.

10:25 A.M.—Discussion by *Eugene Ziskind, M.D., Los Angeles.*

10:35 A.M.—Surgical Treatment of Epilepsy. Pathologic Etiology Other Than Tumor—*William T. Grant, M.D., Los Angeles.*

Paper No. 119. Epilepsy is too often regarded as a disease rather than a symptom of some pathologic condition that is irritating the brain. The first problem in caring for a patient with epilepsy is to decide what area of the brain is being irritated to cause an attack and to ascertain the character of the abnormality at the firing-point. The purpose is to present briefly a few cases in which attacks were not controlled by medical measures and in which a wide variety of pathologic conditions was found. Surgical treatment produced results ranging from satisfactory improvement to complete cure.

10:55 A.M.—Discussion by *William F. Northrup, Jr., M.D., Pasadena.*

11:05 A.M.—Paralysis of Eye Muscles Associated with Intracranial Aneurysms—*E. B. Boldrey, M.D., and Earl Miller, M.D., San Francisco.*

Paper No. 120. Sudden paralysis or paresis of one or all of the muscles supplied by the third cranial nerve should suggest the possibility of intracranial saccular aneurysm of the carotid artery near the course of this nerve. The fourth and sixth cranial nerves may be affected but are not involved as frequently. If there is associated exophthalmus, particularly of the pulsating type, an arteriovenous aneurysm between the carotid artery and cavernous sinus is suspected. The diagnosis of both saccular aneurysm of the carotid and its branches and arteriovenous aneurysms of the carotid and cavernous sinus can be aided by carotid arteriography. Treatment directed toward the prevention of a fatal rupture and death can be instituted when the diagnosis has been arteriographically established.

Friday, May 2. 2:00 P.M. Conference Room 8

Joint Meeting with Sections on Industrial Medicine and Surgery and Radiology

For Program, see Section on Industrial Medicine and Surgery

Saturday, May 3. 9:30 A.M. Music Room

Joint Meeting with Sections on Public Health and Pediatrics

9:30 A.M.—Recent Developments in Mental Health Planning—With Special Reference to the National Mental Health Act—*Lawrence Kolb, M.D., Sacramento (by invitation).*

Paper No. 121. The National Mental Health Act, through its broad provisions for grants-in-aid to states, universities, hospitals, clinics, and individuals for research, the training of personnel, and the assistance in developing preventive mental health programs, will have a far-reaching effect in bringing the importance of mental health before the public and profession and in the development of better means for prevention and cure of mental disease.

9:50 A.M.—Discussion by *Edwin E. McNiel, M. D., Los Angeles.*

10:00 A.M.—Mental Health in the Public Health Program—*Kent A. Zimmerman, M.D., San Francisco (by invitation).*

Paper No. 122. In addition to the usual treatment for personality problems of children, there is a place for prophylactic use of psychiatry in general medicine. By providing an opportunity for physicians and nurses to learn about the emotional structure of the patient-physician relationship, more about the use of the personality as a therapeutic tool, it is felt that those who have had no special psychiatric training can in their everyday practice better treat the emotional component of illness. That part of the health department program in which this experiment is at first to be attempted will be the prenatal, well child, crippled children, and school health clinics.

10:20 A.M.—Discussion by *Oscar Reiss, M.D., Los Angeles.*

10:30 A.M.—The Importance of an Organized Mental Hygiene Program in the Schools—*C. Morley Sellery, M.D., Los Angeles (by invitation).*

Paper No. 123. The mental health problems and needs of school children and the importance of a well-organized mental health program of instruction, guidance, and counseling; the function and operation of child guidance clinics within the school system in solving and preventing the behavior disturbances and neuroses of school children will be discussed.

10:50 A.M.—Discussion by *Marion B. Durfee, M.D., Los Angeles (by invitation).*

11:00 A.M.—A Pediatrician's Observations on Mental Hygiene—*Victor E. Stork, M.D., Los Angeles.*

Paper No. 124. The needs of the growing child for mental health and the role of the pediatrician in the prevention of mental difficulties. How he can foster normal attitudes and relationships and correct some common errors in child management and training.

11:20 A.M.—Discussion by *Carl A. Erickson, M.D., Pasadena.*

PHILIP A. REYNOLDS
Chairman,
Obstetrics and Gynecology

A. M. McCAUSLAND
Secretary,
Obstetrics and Gynecology

SECTION ON OBSTETRICS AND GYNECOLOGY

Philip A. Reynolds, M.D., Los Angeles, *Chairman*
T. Floyd Bell, M.D., Oakland, *Vice-Chairman*
A. M. McCausland, M.D., Los Angeles, *Secretary*

Wednesday, April 30. 2:00 P.M. Conference Room 2

Joint Meeting with Section on Radiology

2:00 P.M.—Lateral Soft Tissue X-Ray in the Diagnosis of Placenta Praevia—*W. R. Schumann, M.D., Los Angeles.*

Paper No. 125. The use of the lateral soft tissue film in the diagnosis of placenta praevia is discussed. The interpretive results of 415 films are reported, and the accuracy assayed by clinical correlation. Using criteria evolved in the accumulation of this series, the films were re-read. The improved results in the second reading are believed to validate these criteria. It is the opinion of the essayist that the obstetrician can, by utilizing these diagnostic criteria, avail himself of a useful adjunct in the management of the suspected placenta praevia.

2:20 P.M.—Discussion by *Monrad E. Aaberg, M.D., Los Angeles, and Kenneth Davis, M.D., Los Angeles.*

2:30 P.M.—Volumetric Readings in Obstetrics—*Douglas R. MacColl, M.D., Los Angeles.*

Paper No. 126. An attempt to determine the value of volume (fetal skull) and volume capacity (maternal pelvis) determinations, and any relationship between fetal skull volume and weight of the baby at birth.

2:50 P.M.—Discussion.

3:00 P.M.—Relative Importance of X-ray Pelvimetry—*Frank Norris, San Francisco.*

Paper No. 127. Contemporary methods of x-ray pelvimetry are reviewed. An attempt is made to integrate x-ray measurements of the pelvis with the dynamics of labor in prognosticating dystocia.

3:20 P.M.—Discussion.

3:30 P.M. — Uterosalpingography — *Edward Leef, M.D., Fresno.*

Paper No. 128. It is important in sterility to know whether the tubes from the uterus are open or closed. If they are closed, then of course it would not be possible for the individual to become pregnant, for the seed could not then come in contact with the egg. If the tubes are open, pregnancy is possible to attain provided both husband and wife are not sterile for another reason. An opaque oil injected into the uterus and into the tubes outlines these structures when an x-ray film is made of the pelvic region and shows if the uterus and tubes are in a normal condition.

3:50 P.M.—Discussion.

Thursday, May 1. 2:00 P.M. Conference Room 4

Joint Meeting with Section on Anesthesiology

2:00 P.M.—Complications of Spinal and Caudal Anesthesia—*Harry Brown, M.D., Los Angeles.*

Paper No. 129. Introductory remarks and a short review of cases recently done. Extent of anesthesia necessary, advantages, indications, contraindications, technique, complications and treatment.

2:20 P.M.—Discussion by *E. C. Cartwright, M.D., Pasadena.*

2:30 P.M.—Caudal Anesthesia in Obstetrics—*A. J. Murrieta, Jr., M.D., Los Angeles*

Paper No. 130. A survey of approximately 4,000 cases, who received caudal anesthesia and analgesia, is reviewed. A comparison is made with other types of analgesia including "low spinal blocks." The advantages and disadvantages of caudal anesthesia are discussed. A discussion of possible medico-legal complications is presented. Complications of caudal anesthesia is again reviewed. Lantern slides.

2:50 P.M.—Discussion by *Hildegard Wilkinson, M.D., Glendale, and W. Benbow Thompson, M.D., Los Angeles.*

3:00 P.M.—Recess.

3:10 P.M.—An Evaluation of Infertility Factors—*Edmund W. Overstreet, M.D., San Francisco.*

Paper No. 131. A discussion, based on case material, of the relative importance and prognostic significance of the various factors which play an etiologic role in infertile marriages. Emphasis on the major physiological gynecologic factors with deprecation of the present tendency to ill-advised and haphazard endocrine therapy.

3:30 P.M.—Discussion by *Erle Henrickson, M.D., Los Angeles and Pendleton Tompkins, M.D., San Francisco.*

3:40 P.M.—Types of Sterilization—*A. N. Webb, M.D., Los Angeles.*

Paper No. 132. Comparison of end results of sterilization with Caesarean section from the experiences of specialists in various sections of United States. Consideration of menopause symptoms following Caesarean hysterectomy in young women.

4:00 P.M.—Discussion by *Donald Tollefson, M.D., Los Angeles, and W. C. Bradbury, M.D., Los Angeles.*

Saturday, May 3. 9:30 A.M. Conference Room 4

9:30 A.M.—Chairman's Address: Emotional Factors in Obstetrical Practice—*Philip A. Reynolds, M.D., Los Angeles.*

Paper No. 133. A review of the increasing interest in psychogenic factors in obstetrical and gynecological practice and a discussion of the obstetricians' need to inform themselves in this field.

9:50 A.M.—Discussion.

10:00 A.M.—Artificial Insemination—*John O. Haman, M.D., San Francisco.*

Paper No. 134. Briefly reviews the history and literature to date. Analyzes 63 cases, including both homologous and heterologous insemination with the successes, failures, and complications encountered with each type of insemination. The importance of special studies, especially the Rh blood types, basal body temperature, tubal patency, and endometrial biopsies is emphasized. The moral, ethical, and psychological grounds for this procedure, as well as the legal implications, and legitimacy of the offspring, are discussed.

10:20 A.M.—Discussion.

10:30 A.M.—Hemothorax in Relation to Ovarian Tumors—*Albert E. Long., M.D., San Francisco.*

Paper No. 135.

10:50 A.M.—Discussion.

11:00 A.M.—Business Meeting and Election of Officers.

ISABELLE H. PERRY
Chairman,
Pathology and Bacteriology

ALBERT G. BROWN
Secretary,
Pathology and Bacteriology

SECTION ON PATHOLOGY AND BACTERIOLOGY

Isabelle H. Perry, M.D., San Francisco, *Chairman*
Albert G. Brown, M.D., Glendale, *Secretary*
William H. Carnes, M.D., San Francisco, *Assistant Secretary*

Thursday, May 1. 9:30 A.M. Conference Room 2

9:30 A.M.—Rhinoscleroma—*Milton Levine, Ph.D., Robert E. Hoyt, Ph.D., O. B. Pratt, M.D., Los Angeles.*

Paper No. 136. Diagnosis of scleroma (rhinoscleroma) can be made in a number of ways:

PATHOLOGY: It is a granulomatous lesion primarily localized on the upper respiratory tract. The gross lesion most frequently described is the circumscribed nodular type which may appear as a single nodule or groups of nodules. Histologically, the ciliated epithelium is transformed into stratified pavement cells. In the deeper layers of the corium, the protoplasm becomes more dispersed and partially disappears; vacuoles and pyknotic nuclei are seen. Perivascular infiltration is found in which the characteristic Mikulicz cells stand out.

BACTERIOLOGY: The organism causing the disease may be isolated uniformly from the nose and throat of the patient suffering from scleroma. It is a gram-negative rod, forming mucoid colonies with the characteristic pattern of sugar fermentations.

SEROLOGY: The complement fixation test, using the above organism as an antigen, consistently is positive in individuals suffering from the disease.

9:50 A.M.—Discussion by *H. James Hara, M.D., Los Angeles.*

10:00 A.M.—Tumors of the Testis and Epididymis—*Henry D. Moon, M.D., San Francisco.*

Paper No. 137. Observations in approximately 100 cases of tumors of the testicle and epididymis are presented. The age incidence, location, hormonal function and classification of the tumors are discussed.

10:20 A.M.—Discussion by *Jesse L. Carr, M.D., San Francisco.*

10:30 A.M.—The Experimental Production of Gonadal Tumors in Rats—*Gerson R. Biskind, M.D., San Francisco, Morton S. Biskind, M.D., and Richard I. Pencharz, Ph.D., New York.*

Paper No. 138. An original technique in which the ovary or the testis is transplanted into the spleen of a castrate rat produces an experimental tumor derived from the transplanted organ. The nature of these tumors and the possible modes of production will be dscussed and illustrated by means of lantern slides.

10:50 A.M.—Discussion.

11:00 A.M.—Experimental Breast Cancer—*Michael B. Shimkin, M.D., San Francisco (by invitation).*

Paper No. 139. A report of experimental induction of mammary tumors in mice.

11:45 A.M.—Discussion by *H. A. Ball, M.D., San Diego.*

12:00 NOON—Chairman's Address: Nomenclature and Coding of Tumor Diagnoses—*Isabelle H. Perry, M.D., San Francisco.*

Paper No. 140. The types of registries in operation are reviewed. What does the pathologist get out of, and what does he contribute to a registry? A progress report is made on the work presented last year. What is the pathologist's part in the future development of tumor records?

12:20 P.M.—Discussion.

Friday, May 2. 9:30 A.M. Ball Room

Joint Meeting with Sections on General Surgery, General Practice, Radiology, and Anesthesiology

For Program, see Section on General Surgery

Saturday, May 3. 9:30 A.M. Conference Room 2

9:30 A.M.—Parathyroid Adenoma—*Justin R. Dorgeloh, M.D., San Francisco.*

Paper No. 141. Extirpation of two large parathyroid adenomas, possibly malignant, was followed by disappearance of the patient's hypercalcemia and bone lesions. Extracts of the tumors produced hypercalcemia in animals. Sections of parathyroid adenomas and giant cell tumors of bone are available, as also are smears of sternal marrow.

9:50 A.M.—Discussion by *E. M. Hall, M.D., Los Angeles.*

10:00 A.M.—Leukemia in the Newborn Infant—*Frederick Proescher, M.D., San Jose.*

Paper No. 142. Report of two cases of leukemia in infants, with a discussion of congenital leukemia. (With slides).

10:20 A.M.—Discussion by *A. M. Moody, M.D., San Francisco.*

10:30 A.M.—Pancreatic Calculi — *W. K. Bullock, M.D., and Hugh A. Edmondson, M.D., Los Angeles.*

Paper No. 143. Eleven instances of pancreatic calculi in 22,000 consecutive autopsies are reported. The pathogenesis and pathology are discussed. Their relationship to acute pancreatitis, chronic pancreatitis, calcification of the pancreas, and alcoholism is emphasized.

10:50 A.M.—Discussion by *A. G. Foord, M.D., Pasadena.*

11:00 A.M. Fibrosis Uteri — *Rosemary Shoemaker, M.D. and J. E. Kahler, M.D., Los Angeles.*

Paper No. 144. The results of histometric and clinical studies in a series of cases of "fibrosis uteri" are compared with similar studies in suitable controls in an attempt to more clearly define the pathologic and clinical criteria for the diagnosis of "fibrosis uteri."

11:45 A.M.—Discussion by *Lyman H. Robinson, M.D., Los Angeles.*

12:00 NOON—Business Meeting and Election of Officers.

E. H. CHRISTOPHERSON
Chairman, Pediatrics

C. I. MEAD
Secretary, Pediatrics

SECTION ON PEDIATRICS

E. H. Christopherson, M.D., San Diego, *Chairman*

C. I. Mead, M.D., Bakersfield, *Secretary*

Alice Potter, M.D., San Francisco, *Assistant Secretary*

Wednesday, April 30. 2:00 P.M. Ballroom

Joint Meeting with Sections on General Medicine and Public Health

For Program, see Section on General Medicine

Friday, May 2. 9:30 A.M. Conference Room 4

9:30 A.M.—Tetrologies, Their Diagnosis and Surgical Treatment—*Mary Olney, M.D., San Francisco.*

Paper No. 145. Presentation of clinical aspects and diagnostic procedure of a group of cyanotic congenital heart cases operated upon.

9:50 A.M.—Discussion.

10:00 A.M.—Epidemic Diarrhea of the Newborn—*Sidney Rosin, M.D., Los Angeles.*

Paper No. 146. Epidemiology, incidence in California, diagnosis, treatment, and prevention of diarrhea in the newborn will be discussed. Experience from an outbreak involving sixty infants is to be drawn upon.

10:20 A.M.—Discussion by *Phillip E. Rothman, M.D., Los Angeles.*

10:30 A.M.—A Review of Common Occular Problems in Children — *Martin T. Koke, M.D., San Diego.*

Paper No. 147. The records of one thousand nine hundred and forty-one children who were seen because of some ocular difficulty are reviewed to determine the relative frequency of the various eye disorders. Some of the cardinal factors in the diagnosis and management of the most common maladies are discussed.

10:50 A.M.—Discussion.

11:00 A.M.—Business Meeting and Election of Officers.

11:15 A.M.—New Drugs Useful in Pediatric Practice —*Clinton H. Thienes, M.D., Los Angeles.*

Paper No. 148. This paper will be an interpretation of the pharmacology of a number of new

drugs. These will include benadryl, pyribenzamine, privine, 2, 3, dimerapto-propanol (BAL), Streptomycin, tyrocidin, sulfamethazine, and curare.

11:25 A.M.—Discussion.

Saturday, May 3. 9:30 A.M. Music Room

Joint Meeting with Sections on Neuropsychiatry and Public Health

For Program, see Section on Neuropsychiatry

SECTION ON PUBLIC HEALTH

Dwight M. Bissell, M.D., San Jose, *Chairman*
Harold D. Chope, M.D., Stockton, *Vice-Chairman*
Malcolm H. Merrill, M.D., Berkeley, *Secretary*

DWIGHT H. BISSELL
Chairman, Public Health

MALCOLM H. MERRILL
Secretary, Public Health

Wednesday, April 30. 2:00 P.M. Ball Room

Joint Meeting with Sections on General Medicine and Pediatrics

For Program, see Section on General Medicine

Thursday, May 1. 9:30 A.M. Conference Room 5

9:30 A.M.—Chairman's Address: What Are the Basic Needs for Public Health?—*Dwight M. Bissell, M.D., San Jose.*

Paper No. 149. As communities become larger and more complex, organized society demands more of its public health service. As people travel more throughout the state, as well as the United States, there is a need for public health in other areas than the community in which one lives. The problem becomes one of determining how much public health can be utilized to good advantage by the people served. Another problem which is discussed is the need for sharing the financial responsibility for public health among various levels of government and among voluntary agencies. Adequate public health protection is discussed in this paper.

9:50 A.M.—The Relationship of the Health Officer and Practicing Physician to the Planning of Hospital and Health Center Facilities in California—*Philip K. Gilman, M.D., San Francisco.*

Paper No. 150. Relationship important as health of a community only as good as of its members. Should be increasing understanding between two groups of doctors. Availability and standards of facilities augmented by such cooperation and association. Medical profession and health officers duty to together develop high quality of medical care.

10:10 A.M.—Discussion by *Edw. Lee Russell, M.D., Santa Ana.*

10:20 A.M.—Community Health Education in Relation to the Private Physician—*Martin Mills, M.D., Richmond.*

Paper No. 151. The paper will include a discussion of various health education projects carried out in Richmond; the part the private physician has played in these projects; and the effect the programs have had on his practice. An outline will be given of a guide to health department activities and services to physicians, which has been prepared for the use of physicians and their secretaries.

10:40 A.M.—Discussion by *L. H. Frazer, M.D., Richmond.*

10:50 A.M.—Integration of the Services of the Physician, the Hospital, and the Health Department—*Edward S. Rogers, M.D., Berkeley.*

Paper No. 152. The services of the physician, the hospital, and the health department are closely interrelated in the prevention of disease and the provision of medical care in the community. How this inter-relationship has worked out in some situations will be described. Plans that have been presented for further integration will be considered.

11:10 A.M.—Discussion by *S. F. Farnsworth, M.D., Oakland.*

Friday, May 2. 9:30 A.M. Conference Room 5

Joint Meeting with C. M. A. Cancer Commission

9:30 A.M.—A Health Department's Role in the Cancer Program—*Lester Breslow, M.D., San Francisco.*

Paper No. 153. Health departments have until recently been concerned largely with vital statistics and communicable disease control. From this experience, several techniques have been developed—record systems, case finding, case holding, health education, and others. These are applicable to the control of cancer, now the second leading cause of death, and, hence, a concern of public health departments. (Discussion to follow next paper.)

9:50 A.M.—The Relation of the Private Physician to the Cancer Control Problem—*Lyell C. Kinney, M.D., San Diego.*

Paper No. 154. It is generally conceded that most early accessible cancer is curable, and that our high mortality rate in cancer is due in part to the period of delay between the incidence of the disease and effective treatment. The physician in private prac-

tice sees the large majority of cancer patients first, and he can be a determining factor in eliminating this delay if he is cancer conscious. One of the most effective methods of cancer control lies in the enlisting of intelligent, forceful cooperation of the private physician in this program.

10:10 A.M.—Discussion by *C. Hiram Weaver, M.D., Hollywood; E. T. Remmen, M.D., Los Angeles; David Wood, M.D., San Francisco, and A. W. Oughterson, M.D., New York.*

10:40 A.M.—Business Meeting and Election of Officers.

10:50 A.M.—The Epidemiological Aspects of Rheumatic Fever—*George C. Griffith, M.D., Los Angeles.*

Paper No. 155. It is believed that the epidemiology of Rheumatic Fever closely resembles that of the hemolytic streptococcus. Rheumatic Fever is now believed to be one of the collagenous diseases. The basic histopathologic lesion is that of an anaphylactic angiitis. The family, the home, the school, and the training camp are believed to be sources of contact with the beta hemolytic streptococcus. The prevention of Rheumatic Fever appears, therefore, to lie in the field of the control of hemolytic streptococcal epidemics.

11:10 A.M.—Discussion by *A. M. Roberts, M.D., Los Angeles.*

11:20 A.M.—The Public Health Responsibility in the Rheumatic Fever Program—*L. S. Goerke, M.D., Los Angeles.*

Paper No. 156. The paper will cover a statistical review of the geographic source of Rheumatic Fever. source of reporting, case finding with a discussion of the need for a coordinated program and survey of facilities and services available compared to the desired facilities and services with emphasis on the problems encountered in working out details and policies.

11:40 A.M.—Discussion by *Roy O. Gilbert, M. D., Los Angeles.*

Saturday, May 3. 9:30 A.M. Music Room

Joint Meeting with Sections on Neuropsychiatry and Pediatrics

For Program, see Section on Neuropsychiatry

GORDON G. KING
Chairman, Radiology

DOUGLAS R. MacCOLL
Secretary, Radiology

SECTION ON RADIOLOGY

Gordon G. King, M.D., San Francisco, *Chairman*
Douglas R. MacColl, M.D., Los Angeles, *Secretary*

Wednesday, April 30. 2:00 P. M. Conference Room 2

Joint Meeting with Section on Obstetrics and Gynecology.

For Program, see Section on Obstetrics and Gynecology

Thursday, May 1. 9:30 A.M. Ball Room

Joint Meeting with Sections on General Medicine, General Surgery, and General Practice.

For Program, see Section on General Medicine.

Thursday, May 1. 2:00 P.M. Conference Room 5

2:00 P.M.—Cardiac Calcifications, Annular and Valvular—*Charles E. Grayson, M.D., Sacramento.*

Paper No. 157. Presentation will include the significance of such calcifications as an aid to the diagnosis of cardiac disease, as well as an aid in the study of cardiodynamics. The annular and valvular types are to be considered, including their differentiation from other calcific shadows and their localization fluoroscopically. The relative significance and age occurrence is to be discussed. Illustrative slides.

2:20 P.M.—Discussion.

2:30 P.M.—Inflammation—as Seen by the Radiologist—*Thomas A. Fullenlove, M.D., San Francisco.*

Paper No. 158. I. Introduction: (a) Reason for Paper. II. Inflammation: (a) Definition; (b) What Happens: (1) Irritant (2) Reaction (3) Experimental; (c) Summary of modern concept of inflammation. III. Effects of X-rays: (a) on bacteria; (b) susceptibility of cells to irradiation; (c) on normal tissues: (1) vascular response; (2) immunological response; (3) permeability change. IV. How x-rays effect inflammation in the light of III: (a) on bacteria; (b) destruction of Polymophonuclear leukocytes releasing Enzymes; (c) Changed permeability of cell walls; (d) destruction of young fibroblasts; (e) increased phagocytic ability of poly-

morphonuclear leukocytes; (f) increased opsonic index; (g) vaso dilitation. V. Conditions treated: (a) list of conditions, inserting tabulations when present; (b) explanation from experimental data as why results are not 100 per cent.

2:50 P.M.—Discussion.

3:00 P.M.—Radiological Management of Inflammatory Lesions—*Bertram V. A. Low-Beer, San Francisco.*

Paper No. 158-A. Treatment with ionizing radiation of inflammtory lesions has been well recognized by radiologists for many years. There is experimental evidence also available for the rationale of this treatment. Nevertheless, the efficacy of radiation therapy in inflammatory lesions has encountered considerable criticism and occasional doubt among the radiologists and practitioners. Analysis of the literature and personal experience indicates that the efficacy of radiation therapy depends greatly on clinical evaluation of the disease process upon which in turn the proper dosage depends. Radio-therapeutic management and clinical evaluation of the lesions before and after treatment will be discussed in this paper.

3:20 P.M.—Discussion.

3:30 P.M.—Roentgen Cardiac Kymography — *L. Henry Garland, M.D., San Francisco, and Sydney F. Thomas, M.D., Palo Alto.*

Paper No. 159. Experience with some three hundred cases is reviewed and evaluated in the light of comparative values of roentgen kymography and electrocardiography; especially, in coronary artery disease. The study is made in an attempt to demonstrate its usefulness in prognosis and in diagnosis of silent electrocardiographic myocardial infarct.

3:50 P.M.—Discussion.

4:00 P.M.—Business Meeting and Election of Officers.

4:10 P.M.—Business Meeting, Pacific Roentgen Society.

4:30 P.M.—Some Practical Aspects of Radio Isotopes in Medical Diagnosis and Treatment—*Earl Miller, M.D.,—San Francisco.*

Paper No. 160. There will be a description on which of the isotopes are useful, how they are used, for what they are used and a discussion about dosage and difficulties of determining dosages.

5:00 P.M.—Discussion.

Friday, May 2. 9:30 A.M. Ball Room

Joint meeting with Sections on General Surgery, General Practice, Pathology and Bacteriology, and Anesthesiology.

For Program, see Section on General Surgery

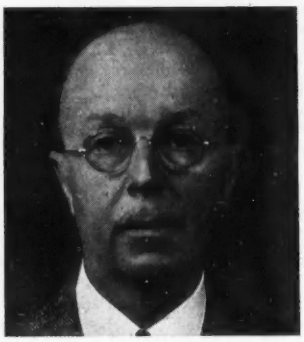
Friday, May 2. 2:00 P.M. Conference Room 8

Joint meeting with Sections on Neuropsychiatry and Industrial Medicine and Surgery.

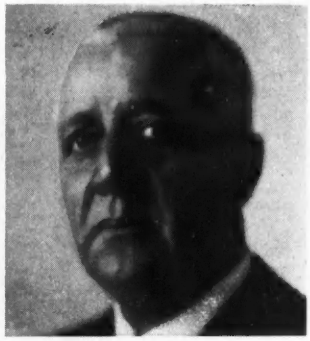
For Program, see Section on Industrial Medicine and Surgery

SECTION ON UROLOGY

Franklin Farman, M.D., Los Angeles, *Chairman*
Lionel P. Player, M.D., San Francisco, *Secretary*



FRANKLIN FARMAN
Chairman, Urology



LIONEL P. PLAYER
Secretary, Urology

Wednesday, April 30. 2:00 P.M. Conference Room 4

2:00 P.M.—Treatment of Hunner Ulcer—*Tracy O. Powell, M.D., Los Angeles.*

Paper No. 161. A brief review of all the reported cases, a short analysis of modern views regarding the etiology, and a practical plan regarding the clinical management of the various types of cases.

2:20 P.M.—Discussion by *R. N. Barnes, M.D., Los Angeles.*

2:30 P.M.—Undescended Testicle — *Edward W. Beach, M.D., Sacramento.*

Paper No. 162. This problem is a perennial one. Proper solution depends much upon the general practitioner who is almost invariably consulted first by the sufferer or his parents. Confusion, uncertainty, and misinformation are still rampant because many of these ill-advised unfortunates delay treatment until the second, third, or even fourth decade when contingent developments force the issue. The author, leaning upon years of urological experience, plus a recent Navy background, seeks herein to review and clarify the subject and to set forth appropriate measures for better management of this all too common and much neglected entity.

2:50 P.M.—Discussion by *Thomas Gibson, M.D., San Francisco.*

3:00 P.M.—Critical Analysis of Treatment of Bladder Tumors—*R. B. Mullenix, M.D., and R. J. Prentiss, M.D., San Diego.*

Paper No. 163. This is a study of 150 private cases presenting carcinoma of the bladder treated by the authors between 1937 and 1946. Analysis and result of different methods of treatment is presented. A plea is made for more radical surgical treatment.

3:20 P.M.—Discussion by *Carl Rusche, M.D., Los Angeles.*

3:30 P.M.—Torsion of the Testicle; Differential Diagnosis and Treatment—*Lloyd Kindall, M.D., and Thomas Nickels, M.D., Oakland.*

Paper No. 164. Diagnosis and differential diagnosis of torsion of the spermatic cord.

3:50 P.M.—Discussion by *Clark Johnson, M.D., San Francisco.*

Thursday, May 1. 9:30 A.M. Conference Room 4

9:30 A.M.—Brief Review of Technique of Suprapublic Prostectomy—*George Reinle, M.D., and James MacDonald, M.D., Oakland.*

Paper No. 165. A brief historical review is mentioned of the more important changes in technique. An improved operative technique which is not radically new, but embodies several minor variations; the use of the oxycellulose as a hemostatic agent; closure of operative bladder incision, and urethral drainage with a Foley catheter. Case reports.

9:50 A.M.—Discussion by *Henry Weyrauch, M.D., San Francisco.*

10:00 A.M.—An Original Technique of Surgery of Deep Paravesical Diverticula in Bad Risks—*Paul A. Ferrier, M.D., Pasadena.*

Paper No. 166. Discussion open.

10:20 A.M.—Discussion.

10:30 A.M.—Scrotectomy for Scrotal Filariasis—*Perry A. Bonar, M.D., San Rafael.*

Paper No. 167. Duration, approximately ten years. Size was 24" x 18" approximately, weight 35 pounds. Discussion of technique, convalescence, final results, and pathology.

10:50 A.M.—Discussion by *Paul Michaels, M.D., Oakland.*

11:00 A.M.—The Cure of Cancer of the Prostate—*Frank Hinman, M.D., and Frank Hinman, Jr., M.D., San Francisco.*

Paper No. 168. The first surgical principle in the treatment of cancer is early diagnosis and radical removal. Thirty years' experience in the application of this principle to cancer of the prostate is presented.

11:20 A.M.—Discussion by *A. J. Scholl, M.D., Los Angeles.*

11:30 A.M.—Chairman's Address: Surgery of the Horseshoe Kidney—*Franklin Farman, M.D., Whittier.*

Paper No. 169. The increasing frequency of recognition of horseshoe (fused) kidney in urological and abdominal diagnosis makes consideration of modern advances in its surgical management a subject of increasing importance, not only to the urologist, but also to the roentgenologist, pediatrisian, and internist as well. (Lantern slides).

11:50 A.M.—Discussion.

12:00 NOON—Business Meeting and Election of Officers.

Friday, May 2. 2:00 P.M. Conference Room 4

2:00 P.M.—Supernumerary Kidney with Aberrant Ureter—*J. Salem Rubin, M.D., Los Angeles.*

Paper No. 170. This is a report of a female, aged 24, who had incontinence since birth in addition to her normal urination.

2:20 P.M.—Discussion by *Carl Rusche, M.D., Los Angeles.*

2:30 P.M.—Aneurism of the Renal Artery—*C. P. Mathé, M.D., San Francisco.*

Paper No. 171. A report of a case in which resection was carried out without removing the kidney.

2:50 P.M.—Discussion by *Roger W. Barnes, M.D., Los Angeles.*

3:00 P.M.—Repair of Vesico-vaginal Fistula—Vaginal Route—*Elmer Belt, M. D., Los Angeles.*

Paper No. 172. New technical details, insuring success. Illustrations by moving pictures.

3:20 P.M.—Discussion.

3:30 P.M.—Tumors of the Ureter—*Nathan Hale, M.D., Sacramento.*

Paper No. 173. Ureteral tumors are uncommon. Those found occasionally, in elderly persons with prostatic hyperplasia, are confusing. Hematuria associated with ureteral tumors and prostatic obstruction complicates diagnosis.

3:50 P.M.—Discussion by *Donald Charnock, M.D., Los Angeles.*

Saturday, May 3. 9:30 A.M. Ball Room

Joint Meeting with Sections on General Practice and General Medicine

For Program, see Section on General Practice

C.M.A. CANCER COMMISSION PRE-CONVENTION CONFERENCES

BILTMORE HOTEL, LOS ANGELES

APRIL 29, 1947

The preconvention conferences sponsored by the Cancer Commission will be held at the Biltmore Hotel on April 29, on the day preceding the opening of the California Medical Association meeting.

PATHOLOGY. Conference Room 2

The preconvention conference on Histopathology will be held from 9 A.M. to 4 P.M. under the chairmanship of Dr. Hugh A. Edmondson. Twenty-five tumor diagnostic problems will be presented and discussed. Members who will attend this conference are requested to bring their own microscopes and to register now with Dr. Edmondson at 1200 North State Street, Los Angeles.

RADIOLOGY. Conference Room 8

The preconvention conference on Radiology will be held at 9:30 A.M. The chairman of this section is Dr. Moris Horwitz, 2009 Wilshire Boulevard, Los Angeles. The secretary is Dr. Wybren Hiemstra, California Lutheran Hospital, Los Angeles. The following program in Radiology has been prepared:

I. DIAGNOSTIC PROBLEMS

1. Gastric Lesion	J. F. Chapman, M.D., Pasadena
2. Bone Lesion	Roy W. Johnson, M.D., Los Angeles
3. Duodenal Lesion	Roy B. Weathered, M.D., Los Angeles
4. Pulmonary Lesion	Ray A. Carter, M.D., Los Angeles
5. Tumor	Gordon King; M.D., San Francisco
6. Bronchial Lesion (?)	Moris Horwitz, M.D., Los Angeles
7. Miscellaneous	
8. The Relation of the State Cancer Control Commission to the Radiologist	Lyell C. Kinney, M.D., San Diego

II. THERAPEUTIC PROBLEMS

1. Bone Tumor	Justin J. Stein, M.D., Los Angeles
2. Gastric Tumor	Kenneth S. Davis, M.D., Los Angeles
3. Lymphoblastoma with 12-year Survival	George S. Sharp, M.D., Los Angeles
4. Intra-oral Lesion	Ian MacDonald, M.D., Los Angeles
5. Tumor (?)	Sydney F. Thomas, M.D., Palo Alto
6. Bone Tumor	E. Siris, M.D., San Francisco
7. Miscellaneous	

Note: Members wishing to present a diagnostic or therapeutic case problem are asked to prepare the material so that it can be distributed amongst the members attending the conference. For example, with a diagnostic problem, positive prints of roentgenograms, sufficient for six separate illiminators are desirable. It is, of course, essential that all cases be pathologically verified.

The Cancer Commission Dinner will be held at 6 P.M., at the Biltmore Hotel, for members of the Cancer Committees of the County Medical Societies. Dr. A. W. Oughterson, Medical and Scientific Director of the American Cancer Society, will be the guest speaker.

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MRS. HARRY E. HENDERSON
C.M.A. Auxiliary President

The President's Message

It is the hope of the Women's Auxiliary to the California Medical Association that all of the doctors will bring with them to the Convention their wives, mothers, sisters, or adult daughters, and that these ladies may take part in our Annual Convention, which will be held in room 3333 at the Biltmore, April 30 to May 2. All of them will be welcome, as delegates, members, or guests, to share in the General Sessions and in the entertainment.

There will be two morning General Sessions, which will be interesting and brief, and for entertainment there will be a luncheon with a fine speaker, a delightful tea in honor of Mrs. S. J. McClendon, and other interesting things to do.

Again we can thank the ladies of the Los Angeles Auxiliary for their hospitality, and for attending with such great care to all the details of Convention arrangements. To Mrs. Lawrence Gundrum, Convention Chairman, and Mrs. Arthur H. Hurd. Local Chairman, and to the many members of their committees, goes our heartfelt gratitude.

MRS. H. E. HENDERSON, *President.*

MRS. R. W. DAHLGREN
C.M.A. Auxiliary Recording Secretary

Room	WEDNESDAY April 30		THURSDAY May 1		FRIDAY May 2		SATURDAY May 3	
	A.M.	P.M.	A.M.	P.M.	A.M.	P.M.	A.M.	P.M.
Ballroom	General Meeting	General Medicine Public Health Pediatrics	General Medicine Surgery General Practice Radiology	General Medicine General Practice	Surgery General Practice Radiology Pathology Anesthesiology	General Meeting and Clinical Pathological Conference	General Practice with Urology and Medicine	
Music Room			Neuropsychiatry	Surgery Indust. Medicine Neuropsychiatry			Public Health Neuropsychiatry Pediatrics	
Conference Room Two		Obstetrics Radiology	Pathology	Eye, Ear, Nose and Throat	General Medicine	Eye, Ear, Nose and Throat	Pathology	
Conference Room Four		Urology	Urology	Obstetrics Anesthesiology	Pediatrics	Urology	Obstetrics	
Conference Room Five		Anesthesiology	Public Health	Radiology	Public Health and Cancer Commission			
Conference Room Six				Anesthesiology				
Conference Room Eight		General Practice			Neuropsychiatry	Indust. Medicine Neuropsychiatry Radiology	Indust. Medicine	
Conference Room Nine			Dermatology	Dermatology	Dermatology			

HOUSE OF DELEGATES MEETS WEDNESDAY AND FRIDAY AT 4 P.M. IN THE MUSIC ROOM.
COUNCIL OF THE C.M.A. MEETS DAILY AT 7:30 A.M. IN CONFERENCE ROOM NUMBER 6.

PRE-CONVENTION REPORTS

Officers • Councilors • Committees • County Societies

REPORTS OF GENERAL OFFICERS

REPORT OF THE PRESIDENT

To the House of Delegates:

The past year has been an active one in California Medicine. Gratifying results have been secured in the campaign conducted by the California Medical Association, for promotion of the "Voluntary Pre-Paid Practice of Medicine." At this writing the continued threat of compulsory insurance is still present. Through the wholehearted support of our membership and an enthusiastic and continued public relations program, the people of California are rapidly becoming better acquainted with the merits of the private practice of medicine.

It has been the pleasure and privilege of your President to visit many of the component County Societies during the year. It has been extremely gratifying to see the excellent cooperation and support given by them in all the organizational affairs of the association.

Respectfully submitted,

S. J. McCLENDON, *President.*

REPORT OF THE PRESIDENT-ELECT

To the President and the House of Delegates:

During the past year, the President-Elect has attended all except one of the regular and special meetings of the Council and all meetings of the Executive Committee. He has participated in the deliberations and actions of the Council and the Executive Committee.

Respectfully submitted,

JOHN W. CLINE, *President-Elect.*

REPORT OF THE SPEAKER OF THE HOUSE OF DELEGATES

To the President and the House of Delegates:

Your Speaker, during the past year, has endeavored to fulfill his interim duties as a member of the Council and Executive Committee. In this capacity I have seen a conscientious, diligent and efficient attempt made by all members of the Council to accomplish the expressed orders of the House of Delegates. Foremost in the minds of the Council has been the desire to represent the will of the members of the California Medical Association. In a year of readjustment, of economic unrest, of political maneuvering by enemies of the medical profession, the decisions made by your Council and Executive Committee have been emergent at times and subject to correction or addition as time has shown necessity. It is for that reason and because every officer wishes to know the desires of the membership that this House of Delegates should familiarize itself with all reports of officers and the Council. Each Delegate should come to this session informed and alert to the needs of our profession. Each should recognize that he has a duty as a Delegate that should not be borne lightly. On every Delegates' shoulders may rest the decision of the whole profession.

As your Speaker, I again call your attention to the need for promptness in attendance at the sessions, your duty to appear before Reference Committees to discuss resolutions concerning which you may have knowledge, and sincerity of purpose to accomplish those things which will redound to the benefit of our patients and the prestige of our profession.

Respectfully submitted,

E. VINCENT ASKEY, *Speaker.*

REPORT OF THE VICE-SPEAKER

To the President and the House of Delegates:

"Once more unto the breach, dear friends, once more,
Or close the wall up with our English dead!
In peace there's nothing so becomes a man
As modest stillness and humility;
But when the blast of war blows in our ears,
Then imitate the action of the tiger:
Stiffen the sinews, summon up the blood."

King Henry V—Shakespeare.

The Vice-Speaker has attended all Council meetings during the past year and has endeavored to fulfill the several special assignments given him.

As the current battle lines of the perennial attack on scientific medicine become more clearly discernible, it is heartening to note that the California Medical Association has enhanced its position materially as compared with the situation two years ago. We have an excellent public relations program, thoroughly integrated and most capably directed. Our state-wide plan for the pre-payment of the costs of illness is giving satisfaction, meeting with popular acceptance and expanding in a praiseworthy manner.

Our contention that medical economics is just one phase of the general problem of economics and that the adoption of panaceas and paternalism in medicine would inevitably result in the extension of such fallacies to the entire business community, has found ready approval and elicited much genuine support. We have demonstrated our awareness of the problems involved in medical care and our eagerness to seek and achieve real solutions. We have made many friends where friendship really counts. Even some of our enemies have begun to doubt that we are quite as bad as they formerly believed.

But—we must not for one moment let down our guard.

Respectfully submitted,

L. A. ALESEN, *Vice-Speaker.*

REPORT OF THE CHAIRMAN OF THE COUNCIL

To the President and the House of Delegates:

During the year I have served as Chairman of the Council I was present at all the meetings of the Council, and likewise served regularly on the Executive Committee and was present at the meetings thereof.

It is becoming increasingly necessary for the Councilors to put in more time in a business of the size of that we represent, which they have willingly done during the year.

It is my desire to thank all the members of the Council, as well as the various departmental executives in the California State Medical Association, for their cooperation during the past twelve months.

Respectfully submitted,

EDWIN L. BRUCK, *Chairman of the Council.*

Report of the Council

To the President and the House of Delegates:

The Council submits its report for the period from the close of the 1946 Annual Session to mid-February, 1947.

1. *Meetings.*

The Council to date has held four meetings, including an organization meeting of May 10, 1946, and regular meetings on September 8, 1946, November 10, 1946, and January 12, 1947. Meetings are scheduled for March 15 and 16, 1947, and for April 29, 1947, as well as the daily meetings during the 1947 Annual Session.

In addition to holding its own meetings the Council has reviewed the actions of the Executive Committee at its meetings of September 8 and October 16, 1946, and January 22 and February 5, 1947.

Council minutes have been printed regularly in the official journal and it is hoped that Association members have taken the opportunity to keep abreast of the deliberations of the Council. It is noteworthy that the Association's affairs have grown to the point where two-day Council meetings now appear necessary. In addition to such meetings, the Council is prepared to consider the actions taken by the Executive Committee, which is prepared to meet every two weeks or at such intervals as appear advisable.

2. *Public Policy and Legislation.*

The Council has been pleased to approve the activities of the Committee on Public Policy and Legislation. This committee has performed nobly in the interests of all Association members and merits the highest commendation for its activities and accomplishments. Legislative prospects for 1947 present numerous problems, particularly with Governor Warren's compulsory health insurance bill again up for consideration. In addition to this proposal, there are numerous bills affecting the public health and the practice of medicine in which the Association is vitally interested and on which we can count upon the effective services of this committee. The Council has consistently approved the actions of the committee and from time to time has appropriated the funds necessary to carry on the committee's work.

3. *Industrial Accident Commission.*

Late in 1946 the Industrial Accident Commission of the State of California put into effect a new and complete schedule of fees applicable to industrial accident cases. The Council is pleased to note the institution of this schedule and to commend the special committee of the Association which worked long and tirelessly in bringing about its adoption. The Council recognizes that the present schedule of fees may not be entirely adequate or equitable in all cases but calls attention to the fact that the adoption of this schedule represents a major victory in that the Industrial Accident Commission has taken jurisdiction in this case and has actually approved a more complete and up-to-date fee schedule. It is believed that inequities in the present schedule may be adjusted through later negotiations.

4. *California Physicians' Service.*

The Council has followed with the greatest interest the progress of California Physicians' Service. Representatives of C.P.S. have appeared as invited guests at all Council meetings and have reported regularly to the Council on all actual and proposed changes in C.P.S. policy and operation. In turn, the Council has been represented at C.P.S. Trustees' meetings, so that a direct liaison has been maintained between the two organizations.

It is the belief of the Council that C.P.S. has been operated both in the public and professional interest in the past year and that it is due the commendation of the medical profession for its rapid and effective development in the face of numerous obstacles. Among these may be mentioned the lack of adequate office space, the need of more trained personnel, the physical problems presented in a membership growth of 140 per cent in one year and the necessary delays occasioned by joint operations with other organizations. Despite all such handicaps, C.P.S. was able in 1946 to increase its membership from 176,000 to more than 432,000 and to bring its professional membership up to more than 7,600 physicians.

The Council has noted with interest that the Trustees of C.P.S. have given close consideration to the recommendations in the "Chandler Committee" report which was adopted by the 1946 House of Delegates. The Council has seen the introduction into C.P.S. procedures and policies the majority of these recommendations and believes that those recommendations which have not yet been put into effect are under study and will be instituted at the earliest possible date.

The C.P.S. program for treatment of veterans' service-connected ailments represents one of the most valuable services which C.P.S. has been able to perform to date. Through this program the medical care of more than 1,300,000 veterans has been retained by the home-town doctors rather than being handled in veterans' hospitals which are often inconvenient for the patient and his family. The Council soundly commends C.P.S. for this program, which it believes is being soundly operated for the benefit of the patient and the physician alike.

5. *Cancer Commission.*

The Council has been kept in close touch with the program of the Cancer Commission, which the Council wishes to congratulate upon its progressive program. The Cancer Commission has cooperated most closely with the California Division of the American Cancer Society, has employed a medical director to assist in establishing a statewide effective cancer detection and treatment program, has aided in the employment of a full-time executive secretary for the California Division of the American Cancer Society, has taken the initial steps in a program of educating California physicians in early cancer detection and has laid the groundwork for issuance of an up-to-date cancer manual for the use of all California physicians. The Cancer Commission has at all times conferred with the Council and the officers of the C.M.A. in its programs and in the opinion of the Council this commission is embarked upon a public and professional educational course which is bound to show increasingly tangible results in cancer detection and treatment.

6. *State Board of Health.*

The Council and Executive Committee have been pleased to confer from time to time with representatives of the State Board of Health and the State Department of Public Health. Early in 1947 conferences were held in regard to legislative proposals adopted by the State Board of Health and scheduled for introduction into the 1947 session of the Legislature. The Council saw fit to withhold approval from some of these proposals and to confer at greater length with representatives of the State Department of Public Health.

It is the belief of the Council that the State Board of Health and the State Department of Public Health are established by law to oversee the broader aspects of public health in the fields of mass preventive medicine (such as inoculation), sanitation, water supplies, etc. It is likewise the belief of the Council that the State Department of Public Health is not established for the purpose of carrying on the practice of medicine or entering into the clinical

aspects of medical practice. The Council decries any tendency toward such practices and reiterates its stand that the practice of medicine belongs in the hands of the private practitioners. If public health authorities indicate a desire to cross over this dividing line, it is the belief of the Council that the Association should make every effort to see that a strict division of authority and function should be maintained.

7. *Board of Nurse Examiners.*

The attention of the Council was called early this year to a ruling made by the State Board of Nurse Examiners affecting the hours of study and floor duty for nurse students. Representatives of the Association have protested this ruling and the Council has been pleased to join with others in attempting to eliminate from the administrative orders of the Board of Nurse Examiners any ruling which tends to specify maximum hours of study in schools of nursing. It is the belief of the Council that the function of the Board of Nurse Examiners, in common with other state boards operating in the professional fields, is to establish minimum standards of professional attainment and not maximum hours of study. Such boards should concern themselves with professional topics only and should leave to other departments of the state government the establishment and maintenance of hours of employment or study. Otherwise there is bound to result an overlapping of authority which will be, at one time, confusing to the professions and injurious to the public health. The Council urges that the Association go on record in this vein.

8. *University of California at Los Angeles.*

The Council has watched with extreme interest the preliminary steps in the establishment of a new medical school at the University of California at Los Angeles. On behalf of the Association the Council offered its offices to the Regents of the University of California in the quest for a Dean for this school and it now believes that the Association should offer every aid and encouragement to this new school to permit it to become one of the leading medical schools in the country.

9. *Palo Alto Clinic.*

Since before the 1946 Annual Session the Council has considered the terms of a contract between the Palo Alto Clinic and Stanford University for the provision of medical services to Stanford students. In response to various suggestions made by the Council the two parties to this contract have agreed to several changes in the contract terms. At the present time there still remains the question as to whether or not the present contract, as it would be amended by proposals already agreed to by the contracting parties, would satisfy, in the opinion of the Council, the requirements of the Principles of Medical Ethics regarding contract practice.

Without entering into a discussion of the pros and cons of this question, the Council wishes to place in the record the fact that contracts of this nature are not confined to specific localities in their implications; there are numerous schools throughout the state, any one of which might wish to enter into a similar contract with a group of local physicians, and it appears to the Council that the basic considerations of any such proposed contract should be along lines which would be equally applicable to any locality. It also appears to the Council that many problems which might arise in regard to such contracts are of a nature that can and should be handled on a local basis. The Council does not wish to dodge any responsibility in the determination of such problems but it wishes to call attention to the fact that where such matters can be worked out on a local basis, the result is likely to be more satisfactory to those immediately concerned than where an outside body, particularly one of statewide proportions, enters into the discussion in the role of an arbiter or judge. It is believed that the ultimate results, where such problems are settled locally, will be more in keeping with the customs and likes of the immediate locality and those who live there.

10. *Addendum.*

The Council will present to the House of Delegates any further items which come under discussion prior to the 1947 Annual Session, together with such recommendations as are decided upon by the Council.

Respectfully submitted,

EDWIN L. BRUCK, *Chairman.*

REPORT OF THE PRESIDENT OF THE TRUSTEES OF THE C.M.A.

To the House of Delegates:

The Trustees of the C.M.A. is an incorporated body established for the purpose of serving as a holding company for assets accumulated by the Association. The members of the Trustees of the C.M.A. are the members of the Association Council at that time, so that the transactions of the Trustees are identical with the actions of the Council. Under the report of the Treasurer, published on another page, will be found the financial report of the Trustees of the C.M.A., this constituting the accounting by the Trustees for funds held by the corporation and representing the only report which the Trustees make as custodians of these funds.

Respectfully submitted,

SAM J. MCCLENDON, M.D., *President.*

REPORT OF THE SECRETARY

To the President and the House of Delegates:

At the end of the 1946 Annual Session, Doctor George H. Kress, who had served the Association so ably for many years, retired from office. The Council, after considerable deliberation, embarked upon a new policy and decided to appoint a part-time Secretary. The undersigned accepted the appointment with the understanding that it would be on this basis, without salary, and that many of the routine duties formerly pertaining to the office would be encompassed by the Executive Secretary. These duties Mr. Hunton has dispatched with more than usual ability, and in complete cooperation with the Honorary or "Constitutional" Secretary. In view of this fact, many of the items previously reported upon by the Association Secretary will this year be found in the Report of the Executive Secretary.

Your Secretary has attended all of the meetings of the Council and of the Executive Committee, in addition to several other meetings such as those of the Legislative Committee, the Cancer Commission and other bodies appointed by the House. He has attempted to carry out the policies laid down by the Council and to be of assistance in the solution of miscellaneous problems arising in such duties. In accordance with the by-laws, he has also served as Chairman of the Committee on Scientific Work. This involves the preparation of the scientific program for the 1947 Annual Session, and has occupied the major portion of his time in his official capacity.

Together with the Editor, your Secretary spent a most instructive two-hour period inspecting the main office of California Physicians' Service, and reviewing the complicated procedures involved in this vastly important undertaking. He wishes that all members of the Association would take the short time required for such a visit, and

avail themselves of personal contact with the multiple problems of Doctor Larsen and Mr. Bowman.

Your Secretary was both surprised and honored at his appointment following the last Annual Session. He realizes that the obligations of the office in an Association as large as ours are indeed considerable. He accepted the position with the understanding that it would be one of brief duration, designed largely to comply with the letter of our Constitution during the year or years that the amendment pertaining to the medical requirement of our secretaryship is under review by the House of Delegates. After a year's experience, it is his humble belief that the position of Honorary or Constitutional Secretary has potential value to the Association (as has been found by other state medical societies), if only to lend the "medical" viewpoint to certain problems as they arise, and to keep still another member closely cognizant with the disbursement of the large expenditures now authorized by the House of Delegates each year.

Your Secretary wishes to thank the officers of the Association and the staff of the Association's main office for their untiring cooperation and assistance. To Mr. Hunton and Miss Griffin in particular, he wishes to express his gratitude.

Respectfully submitted,

L. HENRY GARLAND, *Secretary*

REPORT OF THE TREASURER

To the President and the House of Delegates:

The actual duties of the Treasurer of the Association are handled in the Association office by the office staff. Your Treasurer, therefore, submits as his report for 1946 the independently audited reports prepared by Hood & Strong, Certified Public Accountants. These reports cover operations of the California Medical Association and the Trustees of the California Medical Association (a corporation) for the period of six months ended June 30, 1946. They also show a balance sheet for both the association and the corporation as of June 30, 1946, and a comparative consolidated balance sheet of both organizations for the same date.

The Trustees of the California Medical Association is maintained as a corporation for the purpose of holding assets which may be accumulated by the California Medical Association. In operation it serves as a safekeeping fund for those assets not required in the day-to-day operations of the Association. Members should consider the combined consolidated balance sheet of both organizations in evaluating the financial position of the Association.

Respectfully submitted,

L. HENRY GARLAND, *Treasurer.*

CALIFORNIA MEDICAL ASSOCIATION

STATEMENT OF INCOME AND EXPENDITURE FOR THE SIX MONTHS ENDED JUNE 30, 1946

INCOME

Dues and General:		
Membership Dues—less portion allocated to "Journal" subscriptions		$516,718.50
Exhibits at annual meeting		11,077.50
California Medical Society—services		250.00
Interest earned		3.50
Other		15.00
		$528,064.50
Official Journal—"California and Western Medicine":		
Advertising	$ 32,591.51	
Members' subscriptions—allocated from dues	15,976.50	
Cash subscriptions	676.26	
	$ 49,244.27	
Total Income		$577,308.77

EXPENDITURE

Administrative	$ 48,499.05
Scientific, educational, and public relations	120,461.81
Official Journal—"California and Western Medicine"	29,917.82
Total Expenditure	$198,878.68
Excess of Income over Expenditure	$378,430.09

EXPENDITURES

FOR THE PERIOD JANUARY 1 TO JUNE 30, 1946

Administrative:		
Salary—Association secretary and treasurer		$ 1,725.00
Salary—executive secretary		6,000.00
Salaries—clerical		4,631.25
Travel expense:		
Secretary		539.06
Officers		174.69
Council		1,733.62
Executive committee		47.61
A.M.A. delegates		427.39
Taxes—payroll		271.64
Annual meeting expense		12,245.64
Legal expense:		
Retainer fee		3,000.00
Other legal expense		520.58
Rent		2,487.10
Office supplies and expense		1,208.14
Postage		367.86
Telephone and telegraph		523.45
Council and executive committee		676.08
Contributions to the United Public Health League		10,017.61
Miscellaneous		1,902.33
		$ 48,499.05
Scientific, Educational, and Public Relations:		
Contributions to medical libraries		$ 2,661.00
Public policy and legislation expense		33,826.05
Department of public relations		73,964.00
Department of public relations—C.P.S. promotion		858.79
Physicians' Benevolent Committee		5,325.50
Other committee activities		3,826.47
		$120,461.81
Official Journal—"California and Western Medicine":		
Salary—editor		$ 2,666.65
Printing		17,558.18
Advertising commission		6,830.34
Wrapping and mailing		1,184.76
Illustrations		285.48
Supplies expense and office postage		1,123.14
Discounts and collection expense		168.28
Reprints		100.99
		$ 29,917.82
Total Expenditure		$198,878.68

CALIFORNIA MEDICAL ASSOCIATION

Balance Sheet As of June 30, 1946

ASSETS

Cash		$390,982.33	
In banks	$390,951.83		
Commercial accounts	$390,345.21		
Savings accounts	606.62		
On hand	3.00		
Petty cash fund	27.50		
Accounts Receivable.		6,114.67	
"Journal" advertisers—total	6,030.24		
Less reserve for doubtful accounts	500.00		
	5,530.24		
Miscellaneous	584.43		
Trust Funds		4,441.45	
Morris Herzstein Bequest	3,130.15		
Benevolence	1,311.30		
Furniture and Fixtures—Nominal value		1.00	
Deferred Charges		758.64	
Rent paid in advance	499.10		
Postage on hand	259.54		
Deposit—United Air Lines		425.00	402,723.09

LIABILITIES

Accounts Payable....		14,535.59	
"Journal" production —accrued expense.	3,873.98		
Accrued expense—other	10,255.62		
Collector of Internal Revenue—withholding tax	317.80		
Miscellaneous	88.19		
Trust Accounts.....		4,441.45	
Unexpended balance of income received under Morris Herzstein Bequest.....	3,130.15		
Benevolence Fund...	1,311.30		18,977.04
Surplus			383,746.05
Representing the amount by which the total assets exceed the liabilities as of June 30, 1946.			
Balance, January 1, 1946		5,315.96	
Add		378,430.09	
Excess of income over expenditure for six months ended June 30, 1946.....	378,430.09		

TRUSTEES OF THE
CALIFORNIA MEDICAL ASSOCIATION
(A CORPORATION)
San Francisco, California
STATEMENT OF INCOME AND EXPENDITURE
FOR THE SIX MONTHS' PERIOD ENDING
JUNE 30, 1946

INCOME

Interest on bonds.....$	1,687.28
Interest on savings accounts.....	18.54
$	1,705.82

EXPENDITURE

Premium on bonds purchased.....$	1,250.00
Audit fee	140.00
Miscellaneous	71.00
$	1,461.00
Excess of Income over Expenditure.....$	244.82

TRUSTEES OF THE
CALIFORNIA MEDICAL ASSOCIATION
(A CORPORATION)
San Francisco, California
Balance Sheet, June 30, 1946

ASSETS

Cash		$ 4,512.04	
Bank of America, N. T. & S. A.....	$ 1,302.12		
Commercial account $782.17			
Savings account 519.95			
Wells Fargo Bank—savings account...	1,626.31		
American Turst Company—savings account	1,583.61		
Investments		146,878.52	
U. S. Government securities	144,000.00		
Accrued interest.....	2,878.52		
Endowment Fund....		262.03	
Bank of America, N. T. & S. A.—savings account	262.03		
Benevolence Fund....		13,477.25	
Crocker First National Bank—savings account.....	13,477.25		$165,129.84

LIABILITIES AND SURPLUS

Members' Contribution to Endowment Fund		$ 262.03	
Benevolence Fund....		13,477.25	13,739.28
Surplus			151,390.56
Representing the amount by which the total assets exceed the liabilities as of June 30, 1946.			
Contributed surplus received from California Medical Association		75,000.00	
Earned surplus.....		76,390.56	
Balance, January 1, 1946	76,145.74		
Net income for year 1946	244.82		

CALIFORNIA MEDICAL ASSOCIATION AND
TRUSTEES OF CALIFORNIA MEDICAL ASSOCIATION (A CORPORATION)
COMBINED COMPARATIVE BALANCE SHEET
As of June 30, 1946

ASSETS	CALIFORNIA MEDICAL ASSOCIATION	TRUSTEES OF THE CALIFORNIA MEDICAL ASSOCIATION	COMBINED JUNE 30, 1946	COMBINED DECEMBER 31, 1945	INCREASE (DECREASE)
Cash	$390,982.33	$ 4,512.04	$395,494.37	$ 58,433.70	$337,060.67
Marketable securities		146,878.52	146,878.52	125,004.36	21,874.16
Accounts receivable	6,114.67		6,114.67	3,480.23	2,634.44
Endowment fund		262.03	262.03	260.73	1.30
Benevolence fund	1,311.30	13,477.25	14,788.55	16,145.75	(1,357.20)
Trust fund	3,130.15		3,130.15	3,114.58	15.57
Furniture, equipment, etc.	1.00		1.00	1.00	
Deferred charges	758.64		758.64	591.66	166.98
Deposit—United Air Lines	425.00		425.00	425.00	
	$402,723.09	$165,129.84	$567,852.93	$207,457.01	$360,395.92
LIABILITIES—RESERVES AND SURPLUS					
Accounts payable	$ 14,535.59		$ 14,535.59	$ 4,174.25	$ 10,361.34
Members' contributions to endowment fund		$ 262.03	262.03	260.73	1.30
Benevolence fund	1,311.30	13,477.25	14,788.55	16,145.75	(1,357.20)
Trust account	3,130.15		3,130.15	3,114.58	15.57
Deferred income				27,300.00	(27,300.00)
Surplus	383,746.05	151,390.56	535,136.61	156,461.70	378,674.91
	$402,723.09	$165,129.84	$567,852.93	$207,457.01	$360,395.92

REPORT OF THE EXECUTIVE SECRETARY

To the President and the House of Delegates:

Your Executive Secretary, in presenting his report for the calendar year 1946, submits the following, segregated in the various divisions of his duties:

1. *General.* The C.M.A. office has been maintained for the proper functioning of Association activities and at the highest possible level of efficiency consistent with this purpose. The office staff consists of four young ladies, three of whom have been in the office for five years or more, and two men who have been added within the past year. Mr. Robert F. Edwards has assumed the duties of Assistant to the Editor and Mr. William P. Wheeler is serving as Assistant Executive Secretary. The entire staff has handled all duties in a businesslike and efficient manner and the thanks of the Executive Secretary, as well as the Association as a whole, are due to all personnel.

During 1946 it was possible to renew or modernize the office equipment, particularly the typewriters and the Mimeograph machine. Other new equipment was purchased as a means of making the office efficient, and one additional room was secured. Three small rooms were thrown into one large room by the removal of partitions, and the resultant space functions in a much more satisfactory and efficient manner than heretofore.

2. *Meetings.* The Executive Secretary has attended all meetings of the Council and the Executive Committee, as well as numerous committee meetings. He has attended the two meetings of the A.M.A. House of Delegates and the A.M.A. Annual secretaries' conference. He has made two trips to Washington and New York in behalf of the Association and has traveled into many parts of California at the request of the county medical societies and the members of the Council.

3. *Financial.* The Association during 1946 adopted a new fiscal year, starting July 1 of each year. This change from the former calendar year fiscal basis was suggested as a means of permitting the adoption of an annual budget at the annual meeting for initiation within a matter of sixty days, rather than eight months later. It is believed that the new fiscal year will allow a more realistic budgeting of Association funds than was formerly possible. In accordance with this change, there are presented in the Treasurer's Report the audited figures for the six months ended June 30, 1946, the interim period brought about by the change from one fiscal period to another. While there are no figures strictly comparable with those contained in this report, it is possible to adduce some comparisons which may be of interest.

Combining the auditor's report for the first six months of 1946 with the Association's own book figures for the final six month of the year, there appears a total revenue for the year 1946 of $652,791, compared with 1945 revenues of $167,171. Total 1946 expenditures were $387,572, compared with $235,532 for 1945. For the year there was a net gain in assets of $265,219, compared with a net loss of $68,361 for the preceding year.

Included in the above figures are revenue of $69,755 and expenses of $57,349 for the official journal, CALIFORNIA MEDICINE. For the year 1945 the comparable figures were $53,329 in revenues and $42,661 in expenses. The resultant net profit for the journal was $12,406 for 1946, an increase of 16.3 per cent over the $10,668 profit shown for 1945. Advertising revenues were $68,350, an increase of 31.6 per cent over sales of $51,933 for 1945, and printing costs of $42,291 were 49.1 per cent higher than 1945 costs of $28,366. The higher printing expenses came from a larger journal to a certain extent but reflect primarily the inflationary prices resulting from higher paper and labor costs. What would ordinarily be figured as a highly satisfactory increase in advertising sales was almost completely washed out by higher production expenses. It is hoped that some improvement in this situation will occur in 1947.

During 1946 the Association, acting through its corporate holding company, Trustees of the California Medical Association, increased its holdings of U. S. Treasury Bonds from $124,000 to $294,000. Surplus funds of the Association, by action of the members of the Council who also serve as members of the Trustees of the C.M.A., have thus been invested in Government securities which are fully negotiable and available for use when and if needed.

4. *California Medicine.* The Association's journal underwent a change in name and format during 1946, adopting the name CALIFORNIA MEDICINE and presenting a new cover and new format on its inside pages. It is noteworthy that these changes have brought to the journal a national recognition from many sources, both professional and commercial. In a meeting of state association editors in Chicago last December, CALIFORNIA MEDICINE was singled out as a shining example of what could be done to modernize and make attractive a state medical journal.

For 1947 there are further changes planned in the journal, all designed to add to its attractiveness, its reader interest and its general usefulness to the Association.

5. *Public Policy and Legislation.* Your Executive Secretary has cooperated with the Committee on Public Policy and Legislation throughout the year. This has involved attendance at various meetings, appearances before legislative committees and numerous conferences. With the 1947 session of the State Legislature now underway, the demands of this portion of the Association's work will grow to larger proportions.

Under this same category there should be mentioned the work of the Conference of Presidents and Other Officers of State Medical Associations. Your Executive Secretary has been privileged to attend the meetings of this body and of its Executive Committee and to participate in some of the planning of this organization, which has attained a nationwide stature and importance in the space of only a few short years.

The Executive Secretary has also continued to function as Executive Secretary of The United Public Health League, a federation of state medical associations which maintains a Washington office. During 1946 this League increased its membership from six to eight state medical associations, all located in the western area. This organization has been recognized as fulfilling an important function in the field of medical legislative representation.

6. *Industrial Medical Fees.* Since late in 1942 the Executive Secretary has worked closely with two special C.M.A. committees in an endeavor to bring about an increase in the fees allowed for medical and surgical services in industrial compensation cases. In the middle of 1946 the Industrial Accident Commission of the State of California recognized this work and adopted a new schedule of fees for such services, the schedule representing what the insurance carriers term a 27 per cent increase over the former fee level. The new schedule became effective November 1, 1946, and the Association in advance of that date mailed a complete fee schedule to all its members. Additional requests for copies of this schedule are still being received daily and a total of more than 12,000 copies has already been distributed. Interestingly enough, some of the departments of the State of California are using the C.M.A. schedule in preference to that printed and distributed by the State itself.

It is recognized that the new fee schedule is not complete and may not be entirely satisfactory to all specialists.

In this connection, members have been urged to send in to the C.M.A. Committee on Industrial Practice their suggestions for improvements. It is hoped that a review of the entire schedule may be had later in the year and any inequities adjusted.

7. *Annual Session.* Arrangements for the 1947 Annual Session are proceeding in orderly fashion and all indications point toward a highly successful meeting. Technical exhibits will again be shown; the exhibitors this year will contribute more than ever before and it is hoped that members attending the session will show their appreciation by looking at the exhibits and visiting with the representatives present.

8. *Advisory Planning Committee.* This committee has met throughout the year, the Executive Secretary presiding over each meeting except one which was held during his absence from California. The reports and recommendations of this committee have been reported in the minutes of the Council, to which the Advisory Planning Committee reports and which has complete authority over any suggestions made by the committee.

9. *A.M.A. Annual Meeting.* Your Executive Secretary was pleased to cooperate in some of the arrangements for the A.M.A. 1946 annual meeting, held in San Francisco. During this period he served as temporary chairman of a new organization of medical society executives; this group was formally organized at the Chicago meeting of the A.M.A. last December and your Executive Secretary was honored by election to its Executive Committee.

10. *Conclusion.* This report would be incomplete without an expression of thanks from the Executive Secretary to the Officers and Councilors of the Association for their constant and ready cooperation and assistance in all respects. Similar thanks go to the officers of the county medical societies, members of the Association committees, A.M.A. Delegates and many others who have been of invaluable aid in many ways.

Respectfully submitted,

JOHN HUNTON, Executive Secretary.....

REPORT OF THE EDITOR

To the President and the House of Delegates:

Since the report of last year there has been elected a new editor and established a new journal, CALIFORNIA MEDICINE.

In May, 1946, after twenty years of faithful service, the editor of CALIFORNIA AND WESTERN MEDICINE, Dr. George H. Kress, retired and the present editor was elected by the Council with the approval of the House of Delegates.

Changes in the Journal have been striking. The name was changed to CALIFORNIA MEDICINE with initiation of volume 65 in July, 1946. This distinctive name seemed appropriate since the Journal no longer was the official journal of the Nevada and Utah Medical Associations. A new cover, distinctive for California, increase in size of the type for scientific articles, rearrangement of articles, editorials and official reports have been carried out and new departments have been added. With the beginning of volume 66, in January, 1947, the style of type has been changed to make reading easier and more attractive.

The principal functions of a state medical journal appear to be educational and informative. It is educational to elevate the standards of medical practice and research in the state and informative to keep the readers abreast of the activities of organized medicine.

Every effort has been made to improve the type of scientific articles in CALIFORNIA MEDICINE. In this effort the Editor has received much cooperation from various members of the Association. In addition to scientific articles, clinical material has been presented in the form of clinical conferences and clinical pathological conferences. Furthermore, an article on medical progress, an interpretive review of some phase of medicine, has been presented with each issue.

Presentation of material on the activities of the California Medical Association has been steadily improving. California Physicians' Service and various groups within the C.M.A. such as the Council, Cancer Commission, Executive Committee and the Public Relations Counsel have been given opportunities to present information of their respective activities. As yet this phase of the Journal's activities has not been developed to the fullest possible extent. The Journal, received by every member of the C.M.A., is in an unusual position to present in an attractive form much informative data regarding official activities of the association and in this way to lead in the development of a sound "public opinion" among doctors of the state.

Other data presented in CALIFORNIA MEDICINE is classified under Editorials, Information, News and Notes, Book Reviews, Letters to the Editor, and Medical Jurisprudence.

Much of the credit for whatever good changes have been made in CALIFORNIA MEDICINE during the past year is due to the efforts of Robert Edwards who, as Assistant to the Editor, has well handled most of the details of running the Journal and establishing the make-up of it, to members of the Editorial Board who have candidly reviewed many papers and made effective suggestions, to Dr. Edgar Wayburn of San Francisco and Dr. Edward Boland of Los Angeles, who have handled the clinical conferences, and to Drs. E. W. Page of Berkeley and A. J. Scholl of Los Angeles, who have taken under their wing the Medical Progress section of the Journal.

Respectfully submitted,

DWIGHT L. WILBUR, *Editor.*

REPORT OF THE LEGAL DEPARTMENT

To the President and the House of Delegates:

The Legal Department submits the following report covering the period from the last session of the House of Delegates to the present time:

Our work has involved legislation activities, preparation and rendering of opinions to the Association and committees and members on various matters, attendance at all meetings of the Council, Executive Committee, Committee on Public Policy and Legislation and Advisory Planning Committee, and attendance at meetings of other standing and special committees. The work of this department day by day is so detailed and voluminous that it is not possible, without unduly extending this report, to do more than touch on the highlights. Furthermore, a published report should not go into detail on matters involving the professional relationship of attorney and client.

1. *Legislation:* The Committee on Public Policy and Legislation has been constantly at work during the entire year, and we have endeavored to carry out all of its instructions and to assist it at all times. Prior to the commencement of the present session of the Legislature, we prepared opinions with respect to numerous legislative proposals and drafted for introduction in the Legislature those particular proposals that were adopted by the Coun-

cil. Since the commencement of the session, we have analyzed all bills introduced relating to or affecting the practice of medicine, and have examined all bills introduced in order to ascertain whether or not medicine was in any way affected. There were over forty-five hundred bills introduced, and several hundred of these affected medicine in one way or another. Between the time of preparing this report and the adjournment of the Legislature, we will constantly be at the service of the Committee on Public Policy and Legislation. There are a great number of bills in the present Legislature that affect the medical profession adversely, and the labor involved in attempting to defeat them is going to consume countless hours. Of course, the bills of major importance are the compulsory health insurance bills, Assembly Bill 1500 and Senate Bill 788; but in addition to these there are well over a hundred other bills that require vigorous opposition. There are a number of bills approved by the Council which will be actively supported, and these will likewise require tremendous effort.

2. *Industrial Accident Commission Fee Schedule:* During the past year the controversy over increase in the Industrial Accident Commission's fee schedule has been temporarily settled by adoption by the Commission of a compromise schedule. This was accomplished after preparing and submitting to the Commission a new petition, and after several public hearings, including one hearing of the Assembly Interim Committee on Insurance. The compromise schedule finally adopted by the Commission involved a substantial increase over prior rates. We will report in more detail with respect to the Industrial Accident Commission fee schedule during the sessions of the House of Delegates.

3. *California Physicians' Service:* Shortly after C.P.S. was organized in 1939, the California Insurance Commissioner contended that it was illegally operating, in that it was not incorporated as an insurance company and in that it had not complied with the insurance laws. We contended that C.P.S. was operating legally because it is a service organization composed of doctors of medicine and is not an insurer. The dispute between the Insurance Commissioner and C.P.S. resulted in commencement of an action in the Superior Court in San Francisco in 1940 by C.P.S., seeking a declaratory judgment on the issue. In the Superior Court the case was decided in favor of C.P.S. The Insurance Commissioner then appealed to the District Court of Appeal, which affirmed the judgment of the Superior Court. The Insurance Commissioner then appealed to the California Supreme Court, which on August 27, 1946, rendered its decision in favor of C.P.S. All seven justices of the court concurred in the conclusion that C.P.S. is not subject to the jurisdiction of the Insurance Commissioner. The court stated:

> "Certainly the objects and purposes of the corporation organized and maintained by the California physicians have a wide scope in the field of social service. Probably there is no more impelling need than that of adequate medical care on a voluntary, low-cost basis for persons of small income. The medical profession unitedly is endeavoring to meet that need. Unquestionably this is 'service' of a high order and not 'indemnity'."

Accordingly, the legal status of C.P.S. has finally been clarified, and its classification as a service organization rather than an insurance company has been vindicated. Aside from the principles involved, the decision of the Supreme Court in favor of C.P.S. has a highly important practical result. In California, by provision contained in the state constitution, the gross receipts of insurance companies are subject to a tax of 2½ per cent. If C.P.S. had been held to be an insurance company, it would have become liable for payment of the 2½ per cent gross premiums tax. At present, this tax would amount to more than $125,000.00 per year. If the tax had become payable, it would have reduced by that sum the funds available for payment for medical services.

The decision of the California Supreme Court in favor of C.P.S. has received widespread publicity and comment in legal journals throughout the United States, and it is likely that the case will become a major precedent throughout the Nation for the legal classification of prepaid medical service plans.

4. *Attendance at Meetings:* As previously stated, we have attended all Council meetings during the year, all meetings of the Executive Committee, all meetings of the Committee on Public Policy and Legislation, and all meetings of the Advisory Planning Committee. In addition, we have attended a number of meetings of county societies, special committees of the Association, and conferences with representatives of other organizations. In all, during the year the single item of attendance at meetings has consumed over twenty-five full days.

5. *Opinions:* During the year we rendered a number of miscellaneous opinions to members on questions which arose in connection with their practice. Among the subjects covered were: sterilization; proper execution of birth certificates; social security tax; necessity of autopsy permits; hospital staff regulations; admissibility of patients in county hospitals; interpretation of Principles of Medical Ethics; disciplinary procedure in various county medical societies; and admission of new members. We have also passed upon malpractice insurance policies held by a number of members.

In closing, we wish to express our constant desire to service the profession to the best of our ability.

Respectfully submitted,

PEART, BARATY & HASSARD, *General Counsel.*

REPORTS OF DISTRICT COUNCILORS

FIRST COUNCILOR DISTRICT

Imperial, Orange, Riverside, San Bernardino and San Diego Counties

To the President and the House of Delegates:

The great influx of new physicians following D-Day and the return to their homes and former practices of the local ex-service men caused many difficulties in the obtaining of housing and office space. In some instances offices were shared with returnees until they were able to find places for themselves. The County Societies have made notable increases in membership and several new groups and partnerships have been formed. There seems to be general satisfaction with the volume of practice.

There is great general interest in Governor Warren's second attempt to influence the Legislature to socialize California medicine, and an almost universal desire to help protect our profession from this danger of the gradual loss of our liberty.

Respectfully submitted,

H. A. JOHNSTON, *Councilor,*
First District.

SECOND COUNCILOR DISTRICT

Los Angeles County

To the President and the House of Delegates:

Your Councilor for the Second District has attended all of the California Medical Association Council meetings for the past year. The Council as a whole has endeavored to the fullest extent to carry out the instructions given to it by the House of Delegates. Your Councilor from the Second District has at all times had foremost in mind the welfare of the medical profession at large and has acted upon all matters before the Council, endeavoring to represent our District the way that you have instructed me through the House of Delegates.

I again ask that all of the Delegates and Alternates, as well as all of the members of the medical profession will attend all of the meetings of the House of Delegates when it convenes in May of 1947, here in Los Angeles, at the Biltmore Hotel. All members of the California Medical Association are welcome.

The minutes of the Council have been published in CALIFORNIA MEDICINE at regular intervals for your study. I hope that you have read them completely and thoroughly.

Respectfully submitted,
JAY J. CRANE, *Councilor,*
Second District.

THIRD COUNCILOR DISTRICT

Kern, San Luis Obispo, Santa Barbara, Ventura and Inyo-Mono Counties

To the President and the House of Delegates:

Most of the Third Councilor District component societies have been visited by the Councilor during the past year. All are well organized and functioning smoothly. We have found them very well informed regarding political and economic problems confronting the Profession. There are from 25 to 30 per cent more doctors in the District than there were preceding the war. This probably is not too many to care for the increased population that has also occurred.

Respectfully submitted,
H. E. HENDERSON, *Councilor,*
Third District,

FOURTH COUNCILOR DISTRICT

Fresno, Madera, Kings, Tulare, Merced, Mariposa, Calaveras, San Joaquin, Tuolumne, and Stanislaus Counties

To the President and the House of Delegates:

No important organization problem has required attention in this district during the past year.

The members of our County Medical Societies, with very few exceptions, approve the program of the C.M.A. for continued defense of the American way of practicing medicine. The effort to increase the facilities for insurance against illness and hospital costs is better understood and appreciated. The public relations activities, and the promotion of every better scientific medical care are well endorsed.

One of the unsolved problems here, as elsewhere, is the lack of sufficient hospital space and facilities, and trained nurses, to take care of our greatly increased population. The supply of physicians is now ample, but scarcity of office space and housing facilities continues among difficulties for many newcomers.

County Medical Societies show greatly increased memberships. New members are accorded friendly cooperation and consideration.

The duties of the Councilor are given due attention.

Respectfully submitted,
A. E. ANDERSON, *Councilor,*
Fourth District.

FIFTH COUNCILOR DISTRICT

Monterey, San Benito, San Mateo, Santa Cruz and Santa Clara Counties

To the President and the House of Delegates:

Marked changes have taken place in the Fifth Councilor District since the last meeting of the House of Delegates. The influx of new doctors to this district, I am sure, has been even more noticeable than in some of the metropolitan areas. We are happy to welcome these men into our county society and hope they will become imbued with the proper spirit and become interested members in the affairs of the C.M.A.

In Santa Clara County we have followed the lead of other counties in obtaining an executive secretary. It has worked out very well and we would recommend the same to other counties that could see their way clear to employ one. Also, cooperating with other counties of the bay district, we have established a bureau of medical economics which is working out very well.

Good programs have been held to indoctrinate the new members in the type of work carried on by the Santa Clara County Society.

Meetings with the C.P.S. officers have been held throughout the district this year and I am sure that the participating doctors and the officials of the C.P.S. have a better understanding of the mutual problems which have confronted them.

The Woman's Auxiliary has kept up its splendid work throughout the district.

Respectfully submitted,
R. S. KNEESHAW, *Councilor,*
Fifth District,

SIXTH COUNCILOR DISTRICT

San Francisco County

To the President and the House of Delegates:

Since my election to the Councilorship of the Sixth Councilor District in May of 1946, I have attended all of the meetings of the Council as well as of the Executive Committee.

The San Francisco County Medical Society has increased in membership in the past year due in part to the returning of many men from the service, and that institution has now 1,371 members.

The San Francisco County Medical Society has taken a great deal of interest in trying to find office space, to obtain hospital appointments, and otherwise to coordinate the activity of the Veteran's return to San Francisco since the war.

The other activities of the Society consist in forming a new medical economics bureau patterned after the one in the East Bay and which should prove successful.

The other activities of the County Society in San Francisco have been concerned with numerous political problems which faced the medical profession during the last year, and which it again faces at this time.

Increasing interest of all of the members of the San Francisco County in the Medical Society itself and its activities is very gratifying.

Mr. Frank J. Kihm, the Executive Secretary, has proven an asset of great value.

Respectfully submitted,
EDWIN L. BRUCK, *Councilor,*
Sixth District.....

SEVENTH COUNCILOR DISTRICT

Alameda and Contra Costa Counties

To the President and the House of Delegates:

The new program of the Alameda Country Medical Association, inaugurated in 1945 with the employment of Mr. Rollen Waterson as full-time lay secretary, is rapidly approaching a point where it may be described as an unqualified success.

Public relations, properly so called and as distinguished from "publicity," provides the common denominator for the program, which attempts to perfect individual and collective relations within the profession and with the public.

The bureau of Medical Economics, established to improve economic relations of physicians and patients, is well on the way toward the realization of its objective. Incidentally, it is out of the red and self-supporting. Contra Costa County Medical Association is taking advantage of the Alameda County Bureau.

Backed by the work and facilities of the Bureau, the Association has advertised an unconditional guarantee of medical care for everyone in the county, regardless of ability or inability to pay.

Many other accomplishments are listed by the A.C.M.A. Among them is a malpractice insurance program which provides members with broader coverage, effective claims prevention, greater protection, and substantially reduced premiums.

1946 saw the organization of the Bay Area Coordinating committee, the purpose of which is to extend and coordinate the work of the separate counties. The Bureau of Medical Economics now has offices in San Francisco and San Jose, and it is expected that the public relations and malpractice programs will be similarly extended.

Respectfully submitted,

LLOYD KINDALL, *Councilor,*
Seventh District.

EIGHTH COUNCILOR DISTRICT

Alpine, Amador, Butte, Colusa, Eldorado, Glenn, Lassen, Modoc, Nevada, Placer, Plumas, Sacramento, Shasta, Sierra, Sutter, Tehama, Yolo and Yuba Counties

To the President and the House of Delegates:

During the past year I have visited many of the county medical societies in this district and have discussed with them the problems which confront the practice of medicine and have outlined some of the plans which have been formulated for the solution of these problems.

Being located in the legislative center of the state, I have assisted the California Medical Association committees in opposing compulsory health insurance and have cooperated with them in caring for the medical needs of legislators during their stay in Sacramento.

Considerable assistance was furnished the State Employment Stabilization Commission, Department of Employment, in planning medical regulations and management, disability forms, remuneration for examinations, and various other details incidental to the smooth functioning of the medical aspects of sickness disability insurance. I am pleased to report that complete cooperation in every respect was obtained from this commission in arranging these medical details and sincerely hope that similar close liaison continues in future.

Respectfully submitted,

FRANK A. MACDONALD, *Councilor,*
Eighth District.

NINTH COUNCILOR DISTRICT

Del Norte, Humboldt, Lake, Marin, Mendocino, Napa, Siskiyou, Solano, Sonoma, and Trinity Counties

To the President and the House of Delegates:

1. Your Councilor was able to visit the County Societies in a very limited fashion due to the press of practice and many other meetings in this State, in Missouri, Illinois, and in Washington, D. C. Approximately six weeks of the year were consumed in the National Capital, as an observer at the hearings of the Wagner-Murray-Dingel Bill for Compulsory Sickness Insurance (S-1606). Fortunately the legislation never got out of the Committee for a vote, but we are quite sure, had it come to a vote in 1946, it would have been defeated. However, President Truman has again come out favoring a compulsory system and the medical profession will be obliged to fight the measure in Washington as well as Governor Warren's Compulsory Bill, introduced in our State Legislature at the present time.

2. Vallejo and Solano County Medical Society entertained the members of the Societies of the District at a dinner on August 27, honoring President Samuel J. McClendon, and President-Elect John W. Cline. There was no professional program but we all had a good dinner and following this, excellent entertainment and good fellowship.

Dr. Sidney Garfield and Permanente Foundation are still in our hair in Solano County and are still making progress in selling medical service to people living in the housing units as well as having been granted the opportunity to sell such prepaid service to employees of the Mare Island Naval shipyard to the exclusion of any other plan or agency, such as C.P.S. In my last year's report, mention was made that C.P.S. made a mistake when it failed to subsidize the C.P.S. program for six months or a year or longer in this area. My reason for saying this is that I feel that when C.P.S. withdrew from the Chabot Acres Housing area and Sidney Garfield, M.D., and employees moved into the field C.P.S. had covered and where a need for prepaid service had been shown and the people educated to the program, it was very easy for Garfield to carry on in the same Medical Center previously occupied by C.P.S. Garfield's influence seems to have grown and there is now a possibility that he will be able to acquire a hospital in Vallejo or in Vallejo Township and become a real competitor of the existing medical and hospital facilities here. Many doctors are coming to this area and there is now no need for such groups as that of Sidney Garfield, M.D., and associates. There are now forty-eight Doctors of Medicine in Vallejo, as compared to twenty-eight before the war. The city of Napa has likewise gained about the same relative number. Vallejo has more than ample hospital beds as long as the Vallejo Community Hospital continues to operate.

I will visit all my counties before the convention in May.

Respectfully submitted,

JOHN W. GREEN, *Councilor,*
Ninth District.

REPORTS OF COUNCILORS-AT-LARGE

To the President and the House of Delegates:

During this, my first, year as a member, I have attended all the meetings of the Council of the California Medical Association.

While the matters considered by the Council have been many and varied, among the most important were those respecting public relations and the extension of medical care.

During the year there has been steadily carried on, under Council guidance, a campaign to educate the people of the state in the importance of insuring themselves under a voluntary prepaid medical care plan. The eventual success of this project depends upon the satisfaction of the individuals covered with the professional attention rendered by the servicing physicians.

The harmonious functioning of the Council reflects the

increasing strength and unity which is being manifested throughout the Association.

Respectfully submitted,

LOUIS J. REGAN, *Councilor-at-Large.*

To the President and the House of Delegates:

As Councilor-at-Large I have attended all regular and special meetings of the Council and House of Delegates and have taken an active part in the deliberations of these organizations. With this year I am completing my eighth and last year as Councilor-at-Large. These years have been strenuous ones with the ever present compulsory health insurance before us. I believe the profession is better organized and more united than ever before. Our bulwark and safety lies in making voluntary health insurance work.

Respectfully submitted,

E. EARL MOODY, *Councilor-at-Large.*

To the President and the House of Delegates:

It has been my pleasure to attend all meetings of the Council since my election as a Councilor-at-Large at the 1946 meeting. It has been for me, as a freshman member, a year of orientation and education in the responsibilities and workings of the Council and of the many items of business and policy that appear before it for consideration.

Respectfully submitted,

C. V. THOMPSON, *Councilor-at-Large.*

To the President and the House of Delegates:

As one of your Councilors-at-Large, I have regularly attended the meetings of the Council during the past year. In reviewing these meetings it has impressed me that the work of the California Medical Association is constantly growing and that quarterly meetings of the Council are probably inadequate to deal with the problems that are constantly arising. It may well be that more frequent meetings of the Council are in order. As Chairman of the Executive Committee it has seemed to me proper to call more frequent meetings of the Committee in an attempt to relieve the Council of certain minor matters and to acquaint at least a few members with current problems more quickly than would otherwise be the case.

Respectfully submitted,

SIDNEY J. SHIPMAN, *Councilor-at-Large.*

To the President and the House of Delegates:

As a Councilor-at-Large of the California Medical Association, for 1946-1947 I have attended all of the Council meetings, and a number of the component County Society meetings.

I have worked for the advancement of organized medicine to the end that we may pursue the practice of our profession in this state free of political influences and restrictions.

I endorse the C.P.S. as our best weapon of defense in our attempt to preserve our present method of the practice of medicine in California.

Respectfully submitted,

WALTER S. CHERRY, *Councilor-at-Large.*

To the President and the House of Delegates:

It has been my privilege to attend all the meetings of the Council and to take an active part in the interesting but most difficult work carried on by it. I have also attended the meetings of the Council of the Alameda County Medical Association in order to correlate the work of both state and county organizations.

Respectfully submitted,

H. GORDON MACLEAN, *Councilor-at-Large.*

REPORT OF THE EXECUTIVE COMMITTEE

To the President and the House of Delegates:

The Executive Committee has held meetings during the past year and has submitted the decisions of such meetings to the Council for approval. The Executive Committee has been able to filter much of the work of the Council and since the committee consists of only five voting members it has a flexibility in arranging meetings that the Council lacks. All actions of the committee are subject to Council approval.

Respectfully submitted,

SIDNEY J. SHIPMAN, M.D., *Chairman.*

AUDITING COMMITTEE

To the President and the House of Delegates:

The Auditing Committee has performed the functions laid down in the by-laws. The professional audit of the Association's books showed them to be in order and the Committee has submitted its recommendations for the 1948 budget.

Respectfully submitted,

SIDNEY J. SHIPMAN, *Chairman.*

COMMITTEE ON PUBLIC POLICY AND LEGISLATION

To the President and the House of Delegates:

Following the adjournment of the Special Session of the Legislature in 1946, there was a General Election in our state which was of great interest to the entire medical profession. The profession as a whole interested themselves in the election in their particular counties and districts, and we believe the results of this election were generally satisfactory to our profession.

Since the convening of the 1947 Regular Session of the Legislature we are faced with many bills, some of which are not best for the general welfare of the public and better public health. The bills that are deemed detrimental to the quality of medical practice will be strenuously opposed.

There are over 4,000 bills introduced and at this time they have not all been printed so it is impossible to state the number that will affect the general practice of medicine.

Your Committee is grateful to a great many medical men in our state who are always loyal and dependable for assistance at all times.

Respectfully submitted,

D. H. MURRAY, *Chairman.*

ADVISORY COMMITTEE

To the President and the House of Delegates:

Duties of the Advisory Committee have been to keep in contact with the legislators, have frequent meetings with Mr. Ben Read, and make recommendations to the Legislative Committee as to procedure.

Respectfully submitted,

JUNIUS B. HARRIS, *Chairman.*

COMMITTEE ON HEALTH AND PUBLIC INSTRUCTION

Executive Group

George M. Uhl, Chairman, 1949
E. Earl Moody, 1947 C. M. Burchfiel, 1948

To the President and the House of Delegates:

During the past year the committee has kept close watch on activities dealing with public health and public instruction and has attempted to foster a close accord between county medical societies and official health agencies. There appears to be developing an increasing interest, on the part of county societies, in developing better public understanding of medical economics through the use of the press, radio and the development of speakers' bureaus. It is the hope of the committee that activities in the health education field will be markedly increased during the next year.

Respectfully submitted,

GEORGE M. UHL, *Chairman.*

COMMITTEE ON HISTORY AND OBITUARIES

Executive Group

Morton R. Gibbons, Sr., Chairman, 1947
Robert A. Peers, 1948 E. T. Remmen, 1949
George H. Kress, ex officio

To the President and the House of Delegates:

Since the appointment of Dr. George H. Kress to the office of historian of California Medical Association, the efforts of the committee have been to cooperate with Dr. Kress in the plan to discover, secure and preserve all historical data concerning California medicine. All physicians in California and all others who are interested, are urged to preserve and forward to the historian all pertinent historical items which have come to their attention, also to make a serious effort to discover historical information for preservation by the California Medical Association.

A letter is being prepared by Dr. Kress for the secretaries of County Societies, in which will be set forth the character of information desired and details of compilation and presentation. Information in these letters will be available to all C.M.A. members through the County Society secretaries.

Respectfully submitted,

MORTON R. GIBBONS, SR., *Chairman.*

COMMITTEE ON HOSPITALS, DISPENSARIES, AND CLINICS

Executive Group

Clarence E. Rees, Chairman, 1948
Anthony J. J. Rourke, 1949

To the President and the House of Delegates:

The Hill-Burton Bill has been called to the attention of this committee and its application to hospital construction in California is under consideration of the committee. No other matters have been brought to the attention of the committee during the year. A meeting of this committee has been called for the first day of the 1947 annual session of the California Medical Association.

Respectfully submitted,

CLARENCE E. REES, *Chairman.*

COMMITTEE ON INDUSTRIAL AND CONTRACT PRACTICE

To the President and the House of Delegates:

Your Committee on Industrial Practice has been inactive during the year, officially. There are many things which your committee, as individuals and members of this committee, has accomplished and done during this past year.

The new fee schedule for compensation practice has been adopted by the Industrial Accident Commission. The groundwork for this fee schedule was accomplished some time ago and actually put into effect by our legislative Special Committee and our legal advisor, but your committee has felt that part of the actual responsibility for promoting this favorable legislation has been due to its efforts.

At the present time, local problems arising out of employer and employee health plans, and especially industrial hygiene, have been coming more and more into the notice of employer groups, as well as union and other employee associations.

We hope during the years to come that our Committee on Industrial Practice will be able to keep closely in touch with Chamber of Commerce groups and others, so that eventually the problem of preventive medicine and hygiene in industry can be one of the main contributions that can be made by the Medical Association through their Committee.

Respectfully submitted,

DONALD CASS, *Chairman.*

COMMITTEE ON MEDICAL ECONOMICS

Executive Group

H. Gordon MacLean, Chairman, 1948
Howard W. Bosworth, 1946 Wayne J. Pollock, 1947

To the President and the House of Delegates:

No matters or problems have been referred to the Committee on Medical Economics during the past year and no meetings of the Committee have been held. One wonders whether or not standing committees of this type have any real justification for their existence.

Respectfully submitted,

H. GORDON MACLEAN, *Chairman.*

COMMITTEE ON MEDICAL EDUCATION AND MEDICAL INSTITUTIONS

Executive Group

B. O. Raulston, Chairman, 1947
L. R. Chandler, 1948 Francis Scott Smyth, 1949

To the President and the House of Delegates:

Teaching of medical students has been quite considerably affected during the last year. Relatively large numbers of faculty members have returned from military service, have resumed their former positions as full-time teachers or as practitioners who have given a part of their time to teaching in the medical schools. Large numbers of young physicians, many of them having had a paucity of clinical experience during their military service, have returned eagerly to the responsibilities of making ward rounds and assisting in bedside instruction of students. These men themselves are among the most eager and enthusiastic that may be found. This spirit is of necessity passed on to the students with whom they work, and the result is good and wholesome.

The number of academically qualified applicants for admission to medical schools appears to increase. Veterans of the recent war are conspicuous in the list of applicants. A great many others were not eligible for military service. The problem of selecting students for 1947 classes becomes more complicated than ever.

The requests for reviews and additional training for doctors who have returned from military service have continued to be in excess of the opportunities offered. Increased numbers of residencies, review and refresher courses, and prolonged courses in the various departments

of the medical schools have not by any means satisfied the requests for such training. It is hoped that quality, rather than quantity, may be the ruling influence in providing such opportunities as are possible to those who seek additional training.

Respectfully submitted,
B. O. RAULSTON, *Chairman.*

COMMITTEE ON MEDICAL DEFENSE

Executive Group
William A. Key, Chairman, 1948
Nelson J. Howard, 1947 Louis J. Regan, 1949

To the President and the House of Delegates:

During the past year considerable attention has been given to the group type of malpractice insurance as exemplified in Los Angeles and Alameda counties. The concerted program in these localities has in its favor the greater dissemination of malpractice information. It becomes increasingly apparent that there is more and more need for a livelier interest generally in the problems that confront doctors today in the management of this essential part of the practice of medicine. As yet, however, the time does not seem to have arrived for a statewide organization relative to the handling of malpractice insurance. There remains considerable to be done in investigating ways and means of solving this difficult problem. Much has to be done yet in educating the profession in several phases of this type of insurance and to lead them to believe that an affiliation with a sound company is of far greater importance than a reduction in premiums.

Respectfully submitted,
WILLIAM A. KEY, *Chairman.*

COMMITTEE ON PUBLICATIONS

To the President and the House of Delegates:

Until recent years this committee had important duties. Now the Executive Secretary of the Association and the Execuive Committee of the Editorial Board perform all of them, so little ever happens for us to do.

Respectfully submitted,
GEORGE W. WALKER, *Chairman.*

COMMITTEE ON POSTGRADUATE ACTIVITIES

To the President and the House of Delegates:

In the year 1946 there was no meeting of the Committee on Postgraduate Activities.

During the year various colleges, hospitals and clinics throughout the United States offered postgraduate training under the G.I. Bill of Rights for returning veterans from World War II. The Committee has cooperated by assisting and referring men to these various opportunities as they have arisen.

It is recommended that a list of post-graduate courses for veteran and civilian physicians be published in the CALIFORNIA MEDICINE from time to time, in order to apprise California physicians of the opportunities for postgraduate training available to them.

Respectfully submitted,
JOHN C. RUDDOCK, *Chairman.*

COMMITTEE ON PUBLIC RELATIONS

John Hunton, Director

To the President and the House of Delegates:

Again in 1946 the Committee on Public Relations was inactive, its specified functions having been directed to the hands of professional public relations counsel. It has been the privilege of the director to work closely with the professional firm employed and to contribute to its work wherever possible.

Respectfully submitted,
JOHN HUNTON, *Director.*

COMMITTEE ON SCIENTIFIC WORK

To the President and the House of Delegates:

While we have regained some degree of "normalcy" since the end of the War, with resumption of regular four-day Annual Sessions, and such juxta-convention activities as the Cancer Commission Conferences, we are still confronted with the problem of a suitable location for our annual meetings. The Council had hoped—and planned—to hold the 1947 Annual Session at Coronado, but, upon investigation, found facilities so inadequate as to make it impractical. The Committee believes that a meeting in the central or northern part of the state is advisable for many reasons, not least of which is relief for our hard-working Los Angeles colleagues who have been our hosts so often in recent years.

The Committee on Scientific Work has made every endeavor to arrange a program for this year's Annual Session that will be instructive and enjoyable to every member of the California Medical Association. At a joint meeting of the committee with the secretaries of all the scientific sections, a lengthy discussion was had concerning possible changes from past routines that might improve the meetings. The Section Officers have been asked to poll the members of their individual Sections on the question of the desirability of holding more general meetings; and of devoting only one day of the Annual Session to Section meetings (with short, highly technical papers before the Section proper). It is hoped that all members will express their considered opinions on this question, as well as make other suggestions for the general improvement of the meetings, so that the Committee on Scientific Work may be guided by their wishes in arranging future programs.

Respectfully submitted,
L. HENRY GARLAND, *Chairman.*

CANCER COMMISSION

To the President and the House of Delegates:

When the Cancer Commission was organized on April 27, 1931, by the House of Delegates the announced purpose was: I. That adequate means be provided in California for the education of the medical profession in the early diagnosis of cancer; II. That more adequate facilities for the diagnosis and treatment of cancer patients be provided; III. That research work on the nature, cause, behavior and treatment of cancer be encouraged.

In June, 1945, the Council directed the Cancer Commission to act on the Board of Directors of the California Division of the American Cancer Society and to cooperate with that organization. In line with the original policy and under that directive the Cancer Commission reports the following progress for the year 1946-47:

I. *Professional Education.*

A program of refresher courses for physicians has been organized both in Los Angeles and San Francisco. These courses have been developed by special committee of the Cancer Commission with the financial assistance of the California Division of the American Cancer Society.

The Tumor Board of the Los Angeles County General Hospital gave a three-day course on "The Diagnosis of Neoplastic Diseases" from January 6 to 8. There were 40 instructors, and 260 physicians were registered. A similar course will be given in September and the intention is to repeat this course twice a year.

In San Francisco, with the cooperation of the University of California and Stanford University, a refresher course will be given on March 27 and 28. Future courses will be announced later.

The Cancer Commission Studies of 1932 has been revised by a committee consisting of Dr. Leonard G. Dobson, Dr. Otto Pflueger and Dr. Clarence J. Berne in cooperation with a representative group of members of the California Medical Association. The material is ready for publication. It is the intent of the Cancer Commission to publish this revised manual in serial form similar to the Illinois Cancer Bulletin. The Cancer Commission Studies, 1947 Edition, will be sent bi-weekly to all members of the California Medical Association. When completed this will form a loose-leaf book and a binder will be provided for members who request it so that the chapters can be assembled as a reference book for the physician's desk.

The Cancer Commission has developed a Speakers Bureau on cancer that is available to the program committee of all county medical societies in California. Speakers or groups of speakers are available for scientific meetings of the County Society on request. The Commission is also prepared to enlarge this program as requested by any society, giving Cancer "Clinics" in addition to formal addresses, or a "Cancer Day" which would include a public meeting.

II. *Facilities for the Diagnosis and Treatment of Cancer Patients.*

At the beginning of the year there were 20 Consultative Tumor Boards in California. At the present time there are 41 Tumor Boards or Tumor Clinics of some type, 24 of which have been approved by the American College of Surgeons. The Executive Medical Director of the Cancer Commission has visited many of these clinics, conferring with them on matters of organization, records and policy. The California Division of the American Cancer Society has made substantial grants to several of them and is prepared to make similar grants to any approved Board where such funds will not be used to replace public funds in tax-supported hospitals.

In ten other approved hospitals in California the medical staff is considering the formation of a Consultative Tumor Board. The Commission and the California Division of the American Cancer Society will give them all needed assistance in the development of their boards.

The Cancer Commission has developed and published a "Minimum Standards" for Detection Centers and Tumor Boards in California to be used as suggestions for the formation of new units and for those which are asking for subsidy from the American Cancer Society.

Cancer Detection Centers are operating at the Community Hospital in Fresno, the Cottage Hospital in Santa Barbara, and in Los Angeles.

The Cancer Commission, in its Tumor Program, is receiving the full cooperation of the American College of Surgeons. Rear Admiral Lucius Johnson, (USN, Rtd), inspector for the American College of Surgeons, is working closely with the Commission and his services are available to the Commission in any of their problems.

The Cancer Commission is initiating conferences in northern and southern California for representatives of approved Tumor Boards. Hospital staffs contemplating the formation of Tumor Boards will be invited to these conferences. The conferences will primarily be round table discussions of problems, records and policy. Representatives of the Commission, the American College of Surgeons and the California Department of Public Health will assist in these discussions.

III. *Cancer Research.*

Research work in America is now being financed and correlated by the American Cancer Society in cooperation with the Committee on Growth of the National Research Council. Research is also being supported by the National Cancer Institute of the United States Department of Public Health. Twenty-five per cent of the funds raised by the American Cancer Society in California is used for research purposes on the national level. Over $80,000 has been returned to California for research projects.

The members of the Commission acting as members of the Board of Directors and of the Executive Committee of the California Division of the American Cancer Society have given a large amount of time throughout the year toward developing the program and projects of that organization. The state office of the American Cancer Society is still in the process of development which is necessary to make it effective. In 1946 the California Division collected $780,000, of which $460,000 is available for lay and professional education and for service to cancer patients in this state. For April, 1947, the goal is $850,000. sixty per cent of which will remain in California for the cancer control program on the state and county level.

The State Commander of the Field Army of the American Cancer Society, Mrs. Ryer Nixon, has been most generous in her time and effort and she has effectively organized many new county branches.

With the California Division of the American Cancer Society the Cancer Commission has published a "Bulletin of Cancer Control." This bulletin is sent to the officers of the California Medical Association and to the officers of the county medical societies. It is also sent to the county branches of the American Cancer Society to keep them informed on the policy and progress of the program in California. The present mailing list is 2,000.

The Cancer Commission has had the cooperation of Dr. Wilton L. Halverson, Director of Public Health, and Dr. Lester Breslow, Chief of the Bureau of Chronic Diseases. The Commission and the Health Department have cooperated in assisting the Los Angeles County Medical Society to conduct a cancer survey involving all phases of the facilities and needs in that county. This project is nearly completed and the results of the survey will be published during March. This survey will form the pattern of the investigation in the other counties throughout the state.

The Cancer Commission has been asked to cooperate with the Department of Public Health in a series of 13 Cancer Conferences to be held for Public Health Nurses during February and March. The Commission is also investigating plans for the formation of a Central Tumor Registry in California. Hospitals, tumor clinics and physicians may be asked to cooperate with this registry on a purely voluntary basis. There is no plan at this time to ask for compulsory reporting of cancer patients.

The Cancer Commission constantly recognizes that it is the agent of some 8,000 members of the California Medical Association and that it is responsible to the House of Delegates and the Council of the California Medical Association. Its final objectives are to help the physician to be better able to cope with the cancer problem and to obtain more and better facilities for the diagnosis and treatment of cancer patients. In so doing the Commission is cognizant of the problems, rights and responsibilities of the doctor in private practice.

The Commission is grateful for the support and assistance it has received throughout the year from the Council of the California Medical Association and from many of the county medical societies.

Respectfully submitted,

LYELL C. KINNEY, *Chairman.*

REPORT OF EDITORIAL BOARD CALIFORNIA MEDICINE

To the President and the House of Delegates:

The members of the Editorial Board are:

Chairman of the Board:
Dwight L. Wilbur, San Francisco

Executive Committee:
Lambert B. Coblentz, San Francisco
Albert J. Scholl, Los Angeles
H. J. Templeton, Oakland
Dwight L. Wilbur, San Francisco

Anesthesiology:
William B. Neff, San Francisco
Charles McCuskey, Los Angeles

Dermatology and Syphilology:
Paul Foster, Los Angeles
H. J. Templeton, Oakland

Eye, Ear, Nose and Throat:
Frederick C. Cordes, San Francisco
Lawrence K. Gundrum, Los Angeles
A. R. Robbins, Los Angeles
Lewis Morrison, San Francisco

General Medicine:
Mayo H. Soley, San Francisco
O. C. Railsbach, Woodland
Lambert B. Coblentz, San Francisco
John Martin Askey, Los Angeles
W. E. Macpherson, Los Angeles

General Surgery:
Frederick L. Reichert, San Francisco
C. J. Baumgartner, Beverly Hills

Orthopedic Surgery:
Frederic C. Bost, San Francisco
Hugh Jones, Los Angeles

Thoracic Surgery:
John C. Jones, Los Angeles
H. Brodie Stephens, San Francisco

Industrial Medicine and Surgery:
Rutherford T. Johnstone, Los Angeles
John E. Kirkpatrick, San Francisco

Plastic Surgery:
George W. Pierce, San Francisco
William S. Kiskadden, Los Angeles

Neuropsychiatry:
Karl N. Bowman, San Francisco
John B. Doyle, Los Angeles

Obstetrics and Gynecology:
Daniel G. Morton, San Francisco
Donald G. Tollefson, Los Angeles

Pediatrics:
E. Earl Moody, Los Angeles
William G. Deamer, San Francisco

Pathology and Bacteriology:
Alvin G. Foord, Pasadena

Radiology:
John W. Crossan, Los Angeles
R. R. Newell, San Francisco
Alvin J. Cox, San Francisco

Urology:
Clark Johnson, San Francisco
Albert J. Scholl, Los Angeles

Pharmacology:
Windsor C. Cutting, Menlo Park
Clinton T. Thienes, Los Angeles

Public Health:
George Uhl, Los Angeles
William P. Shepard, San Francisco

During the year 1946-1947 Dr. Walter Macpherson of Los Angeles has been appointed by the Council to represent General Medicine and Drs. William P. Shepard, of San Francisco, and Dr. George Uhl of Los Angeles have been appointed to represent Public Health. The latter is a new section of the Editorial Board.

The executive committee of the board considered and approved the extensive changes made in CALIFORNIA MEDICINE.

The members of the board have been called upon frequently to render opinions relative to the publication of papers and have generously and promptly given their opinions.

Respectfully submitted,

DWIGHT L. WILBUR, *Chairman.*

COMMITTEE ON ORGANIZATION AND MEMBERSHIP

To the President and the House of Delegates:

The Committee on Organization and Membership hereby submits a report for the year 1946. There is appended a summary of the County Medical Association memberships for the year 1946 compiled by the central office. According to this compilation, the State Association is accruing a substantial increase in membership.

The various component county societies have instituted from time to time procedures which have been of real benefit to the new members of the State Association. Some of our members are still in military service, but the exact number is hard to calculate at this time. The number of licensed physicians in the state was taken from the 1945 Directory, as the State Board of Medical Examiners did not publish a Directory for 1946 in time for inclusion of the information in this report. Naturally, due to the large influx of physicians during the past year, the figures for the number of men actually practicing in California is incomplete and may be at least 1,200 to 1,500 over the number listed.

The Committee on Organization and Membership feels that numerically and professionally the California Medical Association has made real progress during 1946.

Respectfully submitted,

CARL L. MULFINGER, *Chairman.*

C.M.A. County Society Membership Totals for Calendar Year 1946

County Medical Societies	*Membership in 1945*	*Number Licensed Physicians (1945 Directory)**	*Civilian C.M.A. Members in 1946*	*Military C.M.A. Members in 1946*	*Total C.M.A. Members in 1946*
Alameda	670	711	599	60	659
Butte-Glenn	38	35	38	..	38
Contra Costa	73	99	61	4	65
Fresno	157	133	155	10	165
Humboldt	36	34	37	2	39
Imperial	25	21	18	5	23
Inyo-Mono	11	13	5	3	8
Kern	79	86	85	2	87
Kings	23	20	21	2	23
Lassen-Plumas-Modoc	16	18	10	3	13
Los Angeles	3,247	4,014	3,149	323	3,472
Marin	54	64	49	7	56
Mendocino-Lake	27	35	20	4	24
Merced	33	19	30	1	31
Monterey	73	78	64	4	68
Napa	40	50	35	4	39
Orange	137	136	126	21	147
Placer-Nevada-Sierra	37	36	30	..	30
Riverside	77	101	73	7	80
Sacramento	183	155	179	6	185
San Benito	7	9	5	1	6
San Bernardino	184	177	183	10	193
San Diego	381	431	351	40	391
San Francisco	1,242	1,404	1,234	58	1,292
San Joaquin	112	92	113	10	123
San Luis Obispo	29	31	23	2	25
San Mateo	104	113	100	11	111
Santa Barbara	128	109	120	5	125
Santa Clara	242	216	233	9	242
Santa Cruz	47	40	44	3	47
Shasta	22	17	8	7	15
Siskiyou	12	17	10	1	11
Solano	53	71	49	2	51
Sonoma	76	80	50	19	69
Stanislaus	56	48	55	2	57
Tehama	8	11	7	..	7
Tulare	57	59	46	3	49
Ventura	58	55	58	4	62
Yolo	27	17	26	1	27
Yuba-Sutter-Colusa	29	23	24	1	25
Total	7,910	8,878	7,523	657	8,180

* Note. The numbers of licensed physicians under the respective counties are those which appear in such listings of the 1945 Directory of State Board of Medical Examiners. The State Board of Medical Examiners does not list in the county rosters the names of licensed physicians who are in military service. These are listed in the alphabetical index which commences on page 51 of the 1945 Directory, the name of each such military member being marked by a star. No Directory was published in 1946.

PHYSICIANS' BENEVOLENCE COMMITTEE

Executive Group
Axcel E. Anderson, Chairman
Robert A. Peers Elizabeth Mason-Hohl

To the President and the House of Delegates:

The Physicians' Benevolence Committee has continued in the past year to contribute to the Los Angeles County Physicians' Aid Association and to provide care for other needy physicians or their families wherever located. In 1946 there was only one case outside Los Angeles County and aid was given until the death of the physician.

Total expenditures of the committee in 1946 were $6,100, of which $6,000 went as contributions to the Los Angeles County Physicians' Aid Association. The expenses of this organization have gone up in recent months to as much as $1,200 a month dispensed for direct care, for drugs, food, hospitalization, sanitarium care and other items.

Revenues of the Physicians' Benevolence Committee in 1946 amounted to $7,342.30 of which $5,606.50 came from the California Medical Association and $1,717.80 from the Woman's Auxiliary to the C.M.A. The Committee is grateful to the Woman's Auxiliary for its continued generous support of the Committee's activities.

At the close of 1936 the Committee had $3,636.80 in its working fund, or enough for an estimated six months, and $13,477.25 in its permanent fund. The Los Angeles County Physicians' Aid Association reported $200,547 in its building fund at the close of 1946 and total net worth of $215,437. Inasmuch as practically all of the needy cases appear to gravitate to Los Angeles County from all parts of the state, there has been a suggestion that possibly the Los Angeles County organization and the C.M.A. Benevolence Fund might be amalgamated. Any formal suggestions along this line would be presented to the House of Delegates for final decision.

Respectfully submitted,
AXCEL E. ANDERSON, *Chairman.*

ADVISORY PLANNING COMMITTEE

To the President and the House of Delegates:

The Advisory Planning Committee has met in accordance with the instructions given by the 1946 House of Delegates and has reported regularly to the Council. Recommendations submitted to the Council have been printed in the official journal as a part of the Council minutes.

Respectfully submitted,
JOHN HUNTON, *Chairman.*

CALIFORNIA PHYSICIANS' SERVICE

To the President and the House of Delegates:

This report on the activities of California Physicians' Service in 1946 is preliminary, and will be supplemented by the Annual Report at the meeting of the House of Delegates in May.

SUPREME COURT DECISION

A milestone in the history of C.P.S. was the decision of the Supreme Court of California, ending some six years of litigation with the Insurance Commissioner. The Court declared C.P.S. to be a service organization, operating legally, and therefore would not come under the jurisdiction of the Insurance Commissioner.

CHANDLER COMMITTEE RECOMMENDATIONS

The recommendations of the Chandler Committee as adopted by the Administrative Members at their meeting in 1946 were thoroughly studied by the Board of Trustees and the administration, and, with one exception, they have all been put into effect. This exception was the recommendation that the income ceiling for service contracts be lowered. The trustees asked the administration to gather figures from various organizations within the state on salary increases during the past five years. This material is being compiled and will be given to the trustees before the May meeting of the California Medical Association.

Under the recommendations of the Chandler Committee, the C.P.S. Fee Schedule is to be reviewed biennially by a committee appointed by the Council of C.M.A. This committee has been appointed, under the chairmanship of Dr. William Bender. C.P.S. has furnished to Dr. Bender a considerable volume of correspondence with member physicians making recommendations concerning the fee schedule.

FINANCIAL AND BUSINESS ADMINISTRATION

In line with efforts to improve the financial condition of C.P.S., the unit value has been maintained at $2.00. The deficit has been considerably reduced during the year, and it is the hope of the trustees that C.P.S. will be in a position to pay the par value of the unit before the end of the year. Mr. Anson Herrick, Certified Public Accountant for C.P.S., in making his annual audit, reported to the board a considerable improvement in the accounting, records and administrative procedures of C.P.S. It is hoped that by March 1 the process of forwarding checks to physicians will have been speeded up, so that payment may be expected within 30 days from the time the bills are received by C.P.S.

In November, the administration authorized the firm of McKinsey and Company, a nation-wide business consultant firm, to make a detailed survey of the procedures and systems in effect in C.P.S. This firm spent several months working very closely with C.P.S. personnel. Its final recommendations stated that C.P.S. is basically sound as set up and in accord with accepted business practices. The chief factors they noted were (1) that C.P.S. is a new organization with very few business precedents to follow, and (2) that C.P.S.'s tremendous growth during the past year has caused numerous problems. They recommended certain specific changes in procedures and systems which are now being studied by the administration.

RELATION WITH HOSPITAL ASSOCIATIONS

During the year C.P.S. has been repeatedly advised of efforts being made to coordinate the three Blue Cross Hospital Plans. To date no definite action appears to have been taken, and the situation remains unchanged.

PHYSICIAN MEMBERSHIP

The year 1946 has seen a tremendous growth in physician participation. Between January 1 of 1946 and January 1 of 1947, there was a net gain of 2,038 member physicians. C.P.S. now has 7,881 physician members. Service is available to beneficiaries in all sections of the state.

However, the recommendation of the Chandler Committee under which C.P.S. pays for services rendered by non-member physicians is beginning to show effects. Physician members feel that they have supported the program from its inception and helped to carry the financial burden during the difficult formative years. Under the rules they are bound not to charge those members under the income ceiling any additional fee; whereas non-member physicians, not bound by the rules, may make such charges. Therefore, the member physician is being penalized for his support of C.P.S. The only solution would appear to lie in further education of the beneficiary members.

BENEFICIARY MEMBERS

On January 1, 1946, C.P.S. had 176,886 beneficiary members. One year later, on January 1, 1947, we have

419,832 beneficiary members, an increase of 243,046 persons who were placed on the books as dues-paying members during 1946. This represents an increase in membership of 137 per cent. It is hoped that by the May meeting, C.P.S. will have nearly half a million beneficiary members enrolled. The new groups enrolled during 1946 averaged 83.6 per cent participation.

With the help of several prominent doctors in the Bay Area, we at last signed a contract with the Standard Oil Company of California. Enrollment of this group began in February of 1947, and will continue until May. Standard Oil Company has approximately 19,000 eligible employees. We have also been authorized to contact their designated subsidiaries as soon as the enrollment of the Standard Oil Company is completed. The employees are to receive medical, surgical and hospital care, the dependents surgical and hospital care.

RATE INCREASE

In September of 1946, the board authorized a rate increase of approximately 25 per cent for beneficiary members. This raise was put into effect faster and more smoothly than any previous increase, and as of February 1, approximately 160,000 persons have been notified of the increase. At the same time, the board authorized establishing a year's waiting period for all members enrolled after October for tonsillectomies and adenoidectomies, hernias, hemorrhoidectomies and varicose veins. The waiting periods apply to medical, surgical and hospital care for these conditions.

GRANGE PROGRAM

Enrollment under the State Grange Program has resulted in the addition of 10,179 members, representing at least 55 per cent participation among 215 individual Granges. This contract, developed by C.P.S. at the request of the Grange, is on a three-year progressive basis, providing for an annual review of the contract and experience thereunder. Contracts under the Rural Health Plan have been converted to the Grange Program. Historically the Rural Program represented the first offering of medical care to the farmers as a particular group, but naturally this could not apply as widely as does the Grange Program.

VETERANS' PROGRAM

At the end of the war, the Veterans' Administration in Washington, D. C., was faced with the problem of providing returning veterans with adequate medical service. General Omar Bradley, Chief of the Veterans' Administration, called upon the physicians in California, as well as a number of other states where there was a large concentration of veterans, to render service to these veterans for service-connected disabilities. Beginning nine months ago, California Physicians' Service, under its contract with the Veterans' Administration, has been providing care to the veterans for service-connected disabilities. There are approximately 1,350,000 veterans who reside in California. Under this program the veteran may go to his own family physician in his own home town for such care. As of January 1, C.P.S. physicians have rendered care to 481,238 veterans, and Federal funds have been encumbered in the amount of $1,232,243.11. In addition, some 2,551 veterans have been examined for pension purposes. It is to be realized that C.P.S. has done much in designing new forms for use under the Veterans' Program.

Recently a committee was appointed by the Board of Trustees, consisting of trustees and of representatives of the American Legion, to see if a plan could be developed under which veterans could receive care for non-service connected disabilities, and under which their families could also receive care.

DISSEMINATION OF INFORMATION

In line with efforts to keep the profession fully informed on developments in C.P.S., representatives of the board and of the administration have appeared before some 40 County Medical Societies throughout the state, explaining the Commercial and Veterans' Programs and answering questions. Interest among the societies has been keen and has proved helpful to C.P.S.

C.P.S. is presently developing a quarterly bulletin to be sent to all physician members, which will give them further information about the organization.

SUMMARY

During the year California Physicians' Service has continued to make changes in personnel and procedures, to increase its efficiency. Both physician and beneficiary membership have increased tremendously. As evidenced by Mr. Herrick's report and that of McKinsey and Company, C.P.S. is in an excellent position to make 1947 an outstanding year in its development.

Respectfully submitted,

CHESTER L. COOLEY, *Secretary,*
Board of Trustees.

ANNUAL COUNTY MEDICAL SOCIETY REPORTS

FIRST DISTRICT

Imperial, Orange, Riverside, San Bernardino, and San Diego Counties.

Herbert A. Johnston, Anaheim, *Councilor.*

Orange County Medical Association

With the exception of about six doctors still in Military Service, all our doctors are now back from the Service. About 50 new doctors have come into the County during the past two years. All our meetings are well attended and excellent programs have been available.

A special assessment of $10 per member is to be used to help finance a Medical Library which is now in development at the Orange County Hospital.

LLEWELLYN E. WILSON, *Secretary.*

Riverside County Medical Association

An annual out of town meeting of the Riverside County Medical Association was held at Palm Springs. Dr. Chauncey Leobe was guest speaker at the 1946 meeting.

The second Monday of each month at 8 p.m. the Association meets at the Riverside Community Hospital. A scientific program is presented and is followed by a business session.

The Secretary of the Association publishes a monthly bulletin which is distributed the first week of each month.

CECIL J. LORD, *Secretary.*

San Bernardino County Medical Society

Resumé of the year 1946, finds a marked increase in the medical population of our county. We now have 188 practitioners and specialists as compared with 124 in 1943. The newer members are distributed rather evenly throughout the county. Thus outlying towns for the first time in their history now have their own physicians.

All but a few veterans have returned from the services and are now taking an active part in the Society, occupying all offices and maintaining a majority on the Board of Directors. In addition, the returning veterans have taken on the task of staffing the County Hospital, giving a much needed respite for those who maintained these services in addition to their busy practices during the war years.

THOMAS F. DEMPSEY, *Secretary.*

San Diego County Medical Society

With practically all its members home from the war, the San Diego County Medical Society has at last resumed its peacetime activities. We have received over 60 new members. Eleven have seen fit to retire and a few have resigned to seek fields afar.

Much has been accomplished during 1946. California Physicians' Service has opened a branch office with a capable staff that is gaining new members for us and also establishing better personal relationships with the medical members. A long felt need is being met.

In response to numerous requests a Cancer Trust Fund has been set up under Society auspices to receive funds to supplement the local anti-cancer campaign especially in the matter of affording treatment that might otherwise be unavailable. This, together with the establishment of a tumor clinic at Mercy Hospital, promises to be of great value to the community.

A new non-sectarian hospital under the auspices of an interested group of laymen is being organized and promises to add several hundred beds to relieve our present critical shortage of facilities.

The outstanding accomplishment of the year has been the securing of an Executive Secretary, Mr. K. C. Young. The Society has at last recognized that the job of guiding Society activities has become too big for part-time efforts on the part of the Secretary elected from the membership. New quarters are being established. Our *Bulletin* has been enlarged and put on a monthly basis. Much has already been accomplished as was seen during the recent political campaigns. We are looking forward to greater efficiency in the future and the Secretary is now relaxing and "letting George" do it.

W. H. GEISTWEIT, JR., *Secretary.*

SECOND DISTRICT

Los Angeles County.

Jay J. Crane, Los Angeles, *Councilor.*

Los Angeles County Medical Association

No report from the Los Angeles County Medical Association would be complete without mentioning the large acquisition of members during 1946. As of January 17, 1947, the membership numbered 4,130, with a waiting list of over 300. Of this number, 79 are listed as associate members and 229 as retired members. Because of this increase in membership, the indoctrination program for new members was put into effect and carried out so that new members could become better acquainted with local and state medical organizations, laws, ethics, economics, malpractice prophylaxis, and related subjects. Each applicant was also interviewed and his previous record scrutinized by various sub-committees. It is believed that the program is doing much to encourage new members to take an active part in the Association's work.

The Association is in sound financial condition. There is no indebtedness and a substantial increase in income is derived from the *Bulletin* and real estate holdings.

Due to the unusual growth of membership during the past four or five years, the present headquarters building at 1925 Wilshire Boulevard has become much too small. Plans have been drawn for an addition to the building, but construction cannot be started until labor and materials become available. A small temporary addition is being constructed to give additional space for the office force, but this will add only about 1,000 square feet.

The 75th anniversary of the Los Angeles County Medical Association was observed at a ball at the Biltmore Hotel in January, 1946. At this enjoyable occasion, many of our old officers made appropriate remarks. A history of our Association, written by Dr. E. T. Remmen, was presented to the members. This scholarly piece of work in monograph form will provide a future source book for historians of our society.

During the past year every effort was made to improve public relations, and this included a series of meetings with the Los Angeles Bar Association to acquaint our legal colleagues with some of the problems inherent in the practice of medicine and surgery. Through its various committees, the Association has taken part in the work of county institutions, health departments, medical schools, cancer prevention programs, and other community activities.

By appointment of the Board of Trustees, Dr. Louis J. Regan has been made a part-time Director of Medical Relations, an office for which he is eminently fitted. Mr. Stanley K. Cochems, executive secretary, has continued his radio talks on health topics and during the past year on Station KGFJ presented a program entitled, "If They Had Lived Today," which received wide attention, both locally and nationally.

Two new sections were established during the past year. One was a Section on General Practice, under the presidency of Dr. Eric Royston, which has over 500 members at this present writing. A Section on Allergy was recently authorized by the Council.

This year a directory is being published which will give a brief biographical sketch of each member, together with his photograph. This elaborate volume will be placed in the hands of each member without expense to the Association. In this manner it is expected that members will become better acquainted with their colleagues and know more about their medical education.

The group health and accident insurance was purchased by a large majority of the membership and proved thus far to be a satisfactory arrangment. Plans are under consideration for the possible establishment of a program of group life and retirement insurance.

During February of 1947 the "Annals of Western Medicine and Surgery" came off the press. This publication was authorized by the Council and Board of Trustees and is the first attempt at a scientific publication sponsored by the Association since the "Southern California Practitioner" of bygone days. The editorial board consists of executive officers of the Association and representatives of the various specialty sections.

A majority of the 900 veterans of military and naval service have resumed their practice in this area and it has been gratifying to note the quiet and efficient manner in which the great majority have re-established themselves. Originally, there was a fund of approximately $75,000 available for the purpose of making loans to those who needed money to re-establish themselves in practice. The local medical schools have offered postgraduate courses primarily for veterans, and these courses have been well received.

To build a home and have adequate financial reserves, the Physicians' Aid Association is seeking a fund of $500,000, of which $200,000 is already collected. This home is for the care of disabled and indigent physicians and their dependents, and such an activity is unique among medical societies.

The retiring officers of 1946 made an outstanding contribution to the welfare of organized medicine in Los Angeles County. Dr. Regan, not only as President of the Association but as its legal counselor, and Dr. Remmen, as Secretary-Treasurer, worked hard and accomplished much. The executive secretary, Mr. Cochems, was also outstanding as executive, writer and radio artist. The Council and Board of Trustees had an unusually heavy work-schedule, but fulfilled their duties to the satisfaction of most of the membership.

The whole Society again looks forward to entertaining the State convention this May.

C. L. MULFINGER, *Secretary.*

THIRD DISTRICT

Inyo-Mono, Kern, San Luis Obispo, Santa Barbara, and Ventura Counties.

Harry E. Henderson, Santa Barbara, *Councilor.*

Inyo-Mono County Medical Society

We rejoice with all our colleagues throughout the state at the attainment of a more just fee schedule for industrial accident cases. We feel that our willingness to pioneer in demanding proper fees for such cases was a definite aid to this revision. We found ourselves subject to revilings and calumnies by at least one vindictive insurance company (name upon request); but our firm belief that our cause was just, and that the doctors of the whole state would finally benefit by it, sustained us.

Our Society is still small in numbers. Our territory is large (265 miles from our most northerly to our most southerly doctors). But we have held our meetings monthly, with few exceptions. The dentists of our area, being geographically isolated from their own scientific societies, meet with us and hold office. Our active membership is now seven M.D.s and three D.D.S.s.

L. S. BAMBAUER, *Secretary.*

Kern County Medical Society

The Kern County Medical Society meets every third Tuesday except June, July and August at a dinner session at Stockdale Country Club. Dr. William H. Macdonald was president. Excellent speakers were obtained throughout the entire year.

In February, 1946, C.P.S. and Blue Cross held an enrollment campaign on a community basis, which was very successful. At the November meeting the Medical Society passed a resolution to the effect that members would no longer continue on the visiting staff at the Kern General Hospital until the present difficulties had been cleared up.

The following officers were elected for 1947: James T. Stanton, president; Eric F. Colby, president-elect; Frederick O. Wynia, secretary-treasurer; John K. Coker, William H. Macdonald replaced Keith McKee and Harry Lange on the Board of Directors; J. M. Nicholson succeeded himself; Delegates, C. I. Mead and Eric Colby; Alternates, J. E. Vaughan and Roderick Ogden.

In July of 1946 Dr. Francis J. Gundry died following an operation at Rochester, Minnesota. Dr. Gundry had been a member of this Society since coming to Bakersfield over 35 years ago and had contributed a great deal during his many active years. He was still in active practice at the time of his death.

FREDERICK O. WYNIA, *Secretary.*

San Luis Obispo County Medical Society

The San Luis Obispo County Medical Society with a membership of 33 members in 1946 held 11 meetings, nine of which were given over to scientific programs.

All of the seven members from this Society who left to enter the armed forces have received honorable discharges and reentered private practice. Four of them, however, have relocated outside this county.

Twelve physicians were admitted to membership in the San Luis Obipso County Medical Society in 1946, ten by application and two by transfer from other component county societies. At present there are five physicians in the county who are not members of the county Society. One of them has already filed his application for membership and two others have not established residency long enough to be eligible for membership but will file applications in the near future.

There were no deaths among the membership during the past year, but two members have retired from active practice.

During the past year the Society members have taken an active part on the staffs of the San Luis Obipso County General Hospital in San Luis Obispo as well as on the staff of the northern branch of County Hospital in Atascadero. The cooperation and relationship between the county governing bodies of the hospitals and the respective staffs has been most harmonious and pleasant.

The membership of the San Luis Obispo County Medical Society also held 100 per cent membership in the Public Health League of California and actively supported its program.

In addition to purchasing $500 in Defense Bonds the Society also purchased a new Baloptical Projection Lantern for use of the Society and hospital staff meetings.

Meetings are held the third Saturday of each month, except July, and are usually alternated between the city of San Luis Obispo and some other city in the county. Visiting or new physicians in the county are most welcome and urged to attend the meetings.

The officers for 1947 are: President, H. N. Cookson, M.D., Arroyo Grande; Vice-President, Robert O. Pearman, M.D., San Luis Obispo; Secretary-Treasurer, G. David Kelker, M.D., San Luis Obispo.

The Board of Directors: H. N. Cookson, M.D., Robert O. Pearman, M.D., Edison A. French, M.D., Richard T. Treadwell, M.D., Charles R. Kennedy, M.D.

G. DAVID KELKER, *Secretary.*

Santa Barbara County Medical Society

The Santa Barbara County Medical Society consists of 134 members. Practically all members have returned from the armed services and in addition many new members have arrived since 1944. The monthly meetings are held in Bissell Auditorium the second Monday of each month exclusive of July and August.

Our good fortune in procuring a number of learned speakers who presented scientific papers of lasting interest was instrumental in creating meetings of excellent attendance.

The following were some of the outstanding papers given throughout the year 1946:

February: A. E. Hardison, M.D., acting Medical Director of the American Red Cross, spoke on "Disaster Relief and Blood Procurement."

March: Julius Simon, M.D., of Los Angeles, spoke on "A Flexible Set-up for Evacuation of Injured Personnel at Bougainvilla and Guam." R. C. Surridge, M.D., of Los Angeles, presented a paper on "Surgical Care of War Wounds."

April: Albert Bower, M.D., discussed the subject of "Virus Pneumonia."

May: H. Sjaardema, Ph.D., and Carl W. Rand, M.D., of Los Angeles, spoke on the subject of "Electro-encephalography, Its Technical Aspects and As An Aid to Diagnosis."

June: The hospitality of the Santa Maria doctors was extended to the Society members. A paper was presented by Henry H. Searle, M.D., of the University of California, on "Diseases of the Thyroid and Their Surgical Management."

September: Alan Moritz, M.D., Professor of Legal Medicine at Harvard Law School and Pathologist to the State Department of Massachusetts, spoke on "Official Postmortem Investigation in the Interest of Public Safety." The Santa Barbara Bar Association also were guests at this meeting.

October: Francis McKeever, M.D., of Los Angeles, spoke on "Bone Tumors."

November: Lester M. Morrison, M.D., Assistant Professor of Medicine, and Harry A. Davis, M.D., Professor of Surgery at the College of Medical Evangelists, spoke on "Cirrhosis of the Liver" and "Surgery of the Liver."

December: James J. Short, M.D., Associate Professor of Medicine, Postgraduate School, College of Medical Evangelists, gave an interesting paper on "Obesity."

At the December meeting new officers elected were: President, Delbert H. McNamara, M.D.; President-Elect, Charles A. Preuss, M.D.; Vice-Presidents-at-Large, Lee H. Streaker, M.D., and Albert M. Beekler, M.D.; Secretary-Treasurer, Douglas F. McDowell, M.D.; Delegates, Harry C. De Vighne, M.D., Douglas F. McDowell, M.D., and Alfred B. Wilcox, M.D.; Alternates, H. Verrill Findlay, M.D., Delbert H. McNamara, M.D., and C. W. Henderson, M.D.; Council, Clifford Jones, M.D., J. Gary Campbell, M.D., and Lawrence E. Heiges, M.D.

The Society is now enjoying a membership the highest in its existence and it is our aim in the coming year to create an active interest in medical subjects and to obtain speakers who will stimulate this interest even further.

DOUGLAS F. MCDOWELL, *Secretary.*

Ventura County Medical Society

The Ventura County Medical Society had 59 active, and two retired members at the close of the year. All members who served with the armed forces have returned. In addition to the members who have returned from military service, there has been a net gain of 29 physicians and surgeons in the county.

Meetings are held on the second Tuesday of each month at the Ventura County Country Club at Saticoy. The meetings are preceded by a dinner, as this has been found to increase the average attendance. More stress has been placed on the organizational and economic phases of medical practice during the past year, with three meeting entirely devoted to the discussion of these problems.

The shortage of hospital beds and nurses continues, although the nursing situation is improving slightly. The cost of hospitalization has increased during the past year.

Although the Society cooperates with the allied professions, and engages in some local public relation activities, it is planned to increase these activities during the coming year.

A. A. MORRISON, *Secretary.*

FOURTH DISTRICT

Calaveras, Fresno, Kings, Madera, Mariposa, Merced, San Joaquin, Stanislaus, Tulare, and Tuolumne Counties.

Axcel E. Anderson, Fresno, *Councilor.*

Fresno County Medical Society

During the year 1946 the Fresno County Medical Society held nine regular meetings. In addition a program was arranged with the Legal and Dental Associations of Fresno which is an annual event, highlighted by a speaker from one of the universities, following a day of golf.

At the regular meetings an attempt was made to have out-of-town guest speakers from different medical centers.

During the past year many physicians have returned from the services and many new doctors have started to practice in Fresno County. Office space and available hospital facilities remain very scarce.

The County Society is adopting a Health and Accident

Plan as a group policy for members of the County Medical Society.

W N. KNUDSEN, *Secretary.*

Kings County Medical Society

During the past year eight meetings of the Kings County Medical Society were held. A fine spirit of cooperation among the medical profession has existed and considerable interest has been shown in recent medical work.

WILLIAM F. CHAMLEE, *Secretary.*

Merced-Mariposa Counties Medical Society

During the past year, business meetings in conjunction with dinners proved to be enjoyable social functions as well as necessary business sessions.

It was voted by the members that the Society furnish the staff for the General Hospital, and this practice has worked out very successfully to the satisfaction of all concerned.

Among other local matters of importance, was the adoption of a standard fee schedule for medical and surgical services. This act by the group was an incentive toward closer cooperation and better understanding.

At the close of the year, 25 active members were enrolled in our Society.

C. F. FITZ GIBBON, *Secretary.*

San Joaquin County Medical Society

The year 1946 has been remarkable in the San Joaquin County Medical Society for the return of many of our colleagues from service with the armed forces. It has been possible to resume activities of the Society on a more normal basis than for the past five years.

Ten meetings of the Society were held; two in the form of dinners to honor distinguished colleagues, Doctor Margaret Smythe on February 7, and Doctor Dewey Powell on December 5. The other meetings were as follows: January 2—"War Experiences," Dr. J. O. Eccleston and Dr. Marion Green; March 7—"Traumatic Chest Injuries in Civilian Practice," Dr. Paul Sampson; April 4—"Encephalitis," Dr. E. L. Lennette; May 2—"Specific Treatment of Infections," Dr. Jack Brown; June 6—General relaxation meeting, Dr. George Kress and Dr. John Cline; September 5—"Diabetes," Dr. H. Clair Shepardson; October 3—California Physicians' Service, Dr. Frank Doughty and Mr. John Ballantyne; November 7—"Electric Shock Therapy in Psychiatry," Dr. R. B. Toller and staff.

Membership:

Active members January 1, 1946	77	
Returned from service	25	
Reinstated	2	
New members	8	
Transferred in	5	117
Transferred out	4	
Died	0	
Retired	2	—6
Total membership December 31, 1946		111

H. D. CHOPE, *Secretary.*

Stanislaus County Medical Society

Regular scientific and business meetings were held by the Stanislaus County Medical Society during the year 1946. Members actively participated in the programs.

Some of the members who have been serving with the armed forces have returned to active practice in the county and many new physicians have taken up residence here during the past year. The death of one member, J. A. Porter, of Modesto occurred in 1946.

J. LYLE SPELMANN, *Secretary.*

Tulare County Medical Society

The Tulare County Medical Society has held regular monthly meetings throughout 1946, with Dr. George C. Keiper of Visalia, California, as its president for the year. Guest speakers from various parts of the state added valuable and instructive discussions to the scientific programs.

The past year has seen a steady and healthy increase in the number of active members attending the monthly meetings. At the present writing all but one of the members who had been in military service have resumed their private practice.

At the December meeting election of officers for the coming year was held, and the following officers were elected: Dr. Frank Guido, Visalia, President; Dr. W. B. Parkinson, Porterville, Vice-President; Dr. Debora Pineles, Visalia, Secretary-Treasurer.

DEBORA PINELES, *Secretary.*

FIFTH DISTRICT

Monterey, San Benito, San Mateo, Santa Clara, and Santa Cruz Counties.

R. Stanley Kneeshaw, San Jose, *Councilor.*

Monterey County Medical Society

Regular meetings of the Monterey County Medical Society were held the first Thursday of each month (except June, July and August) and meetings were alternately held in Salinas and Monterey.

The roster of the Society now includes 75 members. The Society mourns the loss of five of its members during the year. These include the secretary, Dr. S. A. Carnazzo of Monterey, California; Dr. E. W. Bingaman and Dr. R. E. Fray of Salinas, California; Dr. William Gratiot of Monterey, California, and Dr. R. A. Wiffen who died while in military service. The following were elected to membership: Dr. D. Stofer, Dr. M. Fong, Dr. E. E. Simard, Dr. F. E. Williams, Dr. Yvonne Champreux, Dr. T. L. MaGee, Dr. A. Nunes, Dr. J. R. Fassett, Dr. D. A. Cleve, and Dr. S. Turner. Dr. M L. Carter, Dr. R. W. Schock, Dr. E. E. Wadsworth, Dr. L. M. Blount, and Dr. J. C. Siemens, transferred from the Society.

Guest speakers for the meetings included Dr. William B. Neff, the Honorable Fred Kraft, the Honorable Fred Emlay, Dr. R. S. Kneeshaw, Dr. E. A. Shaw, Dr. David A. Wood, Dr. A. E. Larson, Dr. Gilbert Thomas, Dr. Mary E. Mathes, Dr. Helen B. Weyrach, Dr. David A. Rytand, and Dr. Vincent Richards. Subjects presented and discussed were state medicine, health, legislation, C.P.S., anesthesia, poliomyelitis, hepatitis, infections of the kidney, intracranial lesions, x-ray diagnosis, nephrosis, and surgical conditions of the chest.

F. HILTON SMITH, *Secretary.*

San Benito County Medical Society

The San Benito County Medical Society has six members in active service. Meetings are held at irregular intervals on the call of the president. No changes in membership occurred during 1946.

JOHN J. HARUFF, *Secretary.*

San Mateo County Medical Society

The present membership of the San Mateo County Medical Society consists of 131 active members, eight associate members and two members still not returned since entering service. During the year, 31 new members were added to the Society, and they are situated well up and down the Peninsula. We jokingly say that "the soup is getting thinner," and at the moment there is no outstanding need for many more medicos.

Our lack of sufficient hospital beds is a problem, and we have been using the Mills Annex with 20 beds, thanks to the Board of Supervisors.

We have an active hospital committee that is investigating plans for a hospital district. The Redwood City area is a step ahead with a hospital district setup in a nebulous state.

ALBERT G. MILLER, *Secretary.*

Santa Clara County Medical Society

With gratification we can clearly note that in 1946 we have, at the county level, inaugurated a definite, concrete, constructive and aggressive program of Medical Public Relations. On May 1, the Society, as its first major step, established a full-time business office, staffed by Mr. Joseph F. Donovan, an experienced and qualified public relations man. We thus became the fourth local County Society in California to have made such a forward step.

Our second major step was to join with the rest of our seven neighboring County Societies in the Bay Area to form the San Francisco Bay Area Medical Societies Coordinating Committee. Specifically, this means that through local County Societies operating a Bureau of Medical Economics we intend to mend some of the broken fences and to stop breaking more fences in the field of doctor-patient economic relations. By the use of a new, modern,

account recovery service, controlled and operated solely by doctors, we believe that we can go a long way in building better relations for medicine at its most critical point of contact with the public.

Our Bureau will soon inaugurate a self-service system of office accounting for doctors, as well as a patient credit reporting service for all of our members.

Among several of the Society's other activities dedicated to improving the public welfare, we did, after no small endeavor, begin operation, on October 31, in conjunction with the local chapter of the Red Cross, our Civilian Blood Donor Center. In our first five weeks 207 pints have been drawn, and 16 different members of our Society have served as volunteer doctors in attendance.

Our Tumor Clinic is now well organized and is satisfactorily functioning. We are now able to note a definite increase in the number of cancer cases detected. By improving our cancer detection methods we can be assured that more patients will come before doctors for treatment at early stages.

This report must include mention of the fact that your Society now has a Hospital Correlating Committee which was appointed in November. Substantial progress has already been made and as soon as the Society is at liberty to do so it will disclose important, hopeful revelations on this project.

A committee has also been at work on the project of finding a suitable building or converted home that might serve as a Medical Center "headquarters." There is much to be gained from many aspects by centralizing the headquarters for such activities as the TB Association, the Cancer Society, the Visiting Nurses Association and our own Medical Society offices. We understand that some of these and similar organizations have already expressed their favor of this proposal. The combined savings in rent alone, as well as the convenience of close proximity of these mutually-affiliated groups is an attraction in itself.

For the benefit of our own members the Society this year inaugurated a group sickness and accident insurance plan which not only benefited policy holders through broader coverage as compared with ordinary similar policies, but by cooperative group action, netted Society members an aggregate cash savings of over $6,000 in premium payments. Other accomplishments of nominal interest included editorial improvements in our monthly *Bulletin*, the publication of a complete membership roster, the establishment of an announcement-card mailing service, two advertisements in three county papers announcing the return of our servicemen doctors, aid in locating and securing office space for new doctors, and other items of personal service.

The better to acquaint our new members with local matters of medical organization, medical public relations, ethics, etc., a plan has been formed for a membership indoctrination course which will begin early next year.

Membership in the Society now stands at 255, and there are 34 applications for membership still pending. Attendance at our monthly meetings has averaged better than 125 members.

In Santa Clara County we believe the Medical Society has demonstrated that a progressive program can be developed if men will work at it.

LESLIE B. MAGOON, *Secretary.*

Santa Cruz County Medical Society

Under the able leadership of President Ruth Frary of Watsonville, the Society had a very successful year. Nine meetings were held. In January, Doctor Peter Cohen of the University of California Medical School discussed the "Rh Factor." The February meeting was a joint meeting with the Mental Hygiene Committee of Santa Cruz County. The speaker was Doctor Arthur Lubin of Stanford Medical School who presented a paper on "Epilepsy." In March the Society was addressed by Doctor Benioff of the San Francisco Hospital Staff on the subject "Diagnostic Problems in Pulmonary Tuberculosis." In April the speaker was Doctor Neff of the Stanford Medical School who presented a paper on "Dynamics of Respiration." In May Doctor Edward B. Shaw of San Francisco addressed the Society on the subject "Modern Methods of Treatment in Infectious Diseases of Childhood." Doctor Roy Coon of Stanford Medical School was the speaker in September and the subject, "Surgery of the Traumatized Abdomen."

The October meeting was a joint meeting with the Monterey County Medical Society. The speakers were Doctor Mary Mathes of Stanford Medical School whose subject was "Diagnosis of Intracranial Lesions in Childhood," and Doctor Helen Weyrauch of San Francisco whose subject was "Diagnosis of Intraabdominal Lesions by Scout Film." The November meeting was addressed by Doctor Norman Freeman of San Francisco on the subject "Peripheral Vascular Diseases."

The annual business meeting was held in December and officers for 1947 elected. The speaker of the evening was Doctor Richard Koch of the San Francisco Department of Health who discussed the "Treatment of Syphilis."

We are happy to report that, at the close of 1946, all of our military members had returned and resumed private practice.

SAMUEL B. RANDALL, *Secretary.*

SIXTH DISTRICT

San Francisco County.
Edwin L. Bruck, San Francisco, *Councilor.*

San Francisco County Medical Society

Nineteen forty-six was a year of continued growth and progress for the San Francisco County Medical Society. Membership reached an all-time record of 1,355 members.

Among the more important developments was San Francisco's participation in the Coordinating Committee of Bay Region Medical Societies. This Committee was formed to consider problems on a regional rather than a county basis in order that the activities of all might be integrated to the best interests of the medical profession. As a result of this Committee the activities of the Bureau of Medical Economics were expanded from Alameda County to San Francisco and Santa Clara counties. This is considered one of the most significant steps ever taken by the Society and one that will be of great value in improving public relations.

Another constructive move accomplished during the year was the formation of a new bureau through which any newspaper reporters' queries about scientific matters will be channeled through the Executive Secretary, who in turn will contact the doctor best qualified to respond. Formation of this bureau has been acclaimed by the newspapers and has received favorable comment in national medical publications.

Steps were taken during the year to improve the "Bulletin." The number of pages increased about 25 per cent and advertising gained correspondingly. The format and cover were improved with the January issue and further improvements will be made in 1947.

The Irwin Memorial Blood Bank continued to grow. The first year the Bank was receiving 200 to 250 donors a month and distributing 100 to 150 units of whole blood. Last year the Bank averaged 1,600 donors monthly and distributed 1,200 to 1,400 units of blood each month.

Due to the needs of the community, the Blood Bank's production reached an all-time high last year. One of the Bank's most gratifying achievements was the reduction in the whole blood service fee from $7.50 to $6.00, effective January 1, 1947. The Bank is operating efficiently and rendering great service. Much credit for its success is due physicians serving on the Blood Bank Commission.

This Society had the pleasure and privilege of acting as host to the A.M.A. when it convened last July 1-5, inclusive, in San Francisco. The various committees functioned smoothly and effectively under the chairmanship of John W. Cline. Many county societies contributed to the entertainment fund and the membership of the San Francisco County Society takes this opportunity of thanking them again for their generous cooperation which made the convention one of the outstanding meetings in the history of the Association.

The Society continued to make every effort to improve the position of the professional staff members of the Health Service System. It initiated a request for a 15 per cent increase in the fee schedule, and when this request was denied last summer by the H.S.S. Directors, the Board conducted a survey of opinion looking toward a renewal of the request. The Society is also considering appropriate action if the request is again denied.

The Society has continued to give support and assistance to C.P.S. New members have been given all the data on the organization and invited to join. The Society noted with pleasure the spectacular increase in beneficiary members and the start of the educational program on a statewide basis.

The Society has continued to give every assistance to the Woman's Auxiliary and is deeply gratified that membership in this organization also reached new high levels last year.

Following a wartime lapse in the scientific programs, section meetings were resumed on a full-scale basis this year. Attendance was good. The scientific and general

meetings attracted a total of 1,530 members throughout the year. One of the most significant developments was the formation of a General Practice Section.

Problems of the returning service doctors were solved as far as possible by the hard-working committees which endeavored to secure hospital facilities, office space and the lack of listings in the telephone book. The Society announced the names of returned service doctors in attractive newspaper advertisements and also published a roster of names, addresses, telephone numbers and specialties of returnees which were distributed to all members of the Society. Costs were paid by the Special Service Fund. Other activities included obtaining part-time jobs and securing post-graduate training for others.

The Special Service Fund, accumulated by the members of this Society for the benefit of veteran doctors, was put to good use in 1946. During the year, loans and gifts were authorized amounting to $13,700. Eighty-seven veteran members had their dues paid at a cost of $8,000. Balance of the fund at the year's end was over $40,000.

ROBERTSON WARD, *Secretary.*

SEVENTH DISTRICT

Alameda and Contra Costa Counties.
Lloyd E. Kindall, Oakland, *Councilor.*

Alameda County Medical Association

Nineteen forty-six was an eventful year for the Alameda County Medical Association. A complete report on our progress during the past year would require a volume. But here are a few of the highlights.

Of first importance—and the gauge and inspiration for everything else—has been the development of our public relations program. This program is firmly established upon the premise that the level of the security and prosperity that is to be enjoyed by the practitioners of medicine will be determined by the degree to which they individually and collectively translate into practice the public relations philosophy of the Association: *the interpretation and direction of every act in terms of the ultimate public good.*

The recently established Bureau of Medical Economics has been developed to a point where it can back up the Association's advertised guarantee of medical care for everyone, regardless of the patients' ability or inability to pay. The services of the Bureau are being constantly expanded and improved. These services are auditing, accounting, collections, credit reporting, medical social service screening, account financing, tax advice, bookkeeping, billing, and postpayment plans.

A group malpractice insurance program has been developed, chief features of which are a preventive program, a retrospective rating plan, the broadest coverage yet written into a malpractice insurance contract, and a premium rate that is from 25 per cent to 65 per cent less than the prevailing California rates. The savings to members during the next year will amount to more than the total of their Association dues. Within five years this saving can be more than doubled. This project, alone, therefore pays the cost of our entire new A.C.M.A. program.

During 1946 the Association took over the operation of the Alta Bates Eastbay Blood Bank. A real estate man, employed full time, assisted returning service men in finding offices. Loans were made to veteran members from our Postwar Benefit Fund. The nation's first two-year sickness disability group health and accident insurance plan was developed by the Association and subscribed by members. The Constitution and By-Laws were revised along more democratic lines. Branches of the Association were organized. A General Practitioners Association was organized, independently of the A.C.M.A. Standards for the improvement of the professional work in Eastbay hospitals were developed and recommended. *The Bulletin* of the Association grew to 64 pages, with more than $1,300 per month in advertising. The Association exhibited its growing power for good by summarily squashing a political move to oust a competent, well-trained municipal public health official. The Association's relations with California Physicians' Service were improved. Other county societies throughout the state were assisted in launching comprehensive programs along the lines of the Alameda plan. *A 137-page History of the Alameda County Medical Association* was written by Dr. Milton Shutes and published by the Association with funds contributed by Mrs. Frank Mackinson. Many new books and periodicals were added to our library. A Bay Area Coordinating Committee was organized, and offices of the Bureau of Medical Economics were opened in San Francisco and San Jose. More than 12,000 telephone calls per month went through the busy A.C.M.A. switchboard (which does not include doctors' telephone secretarial service). The membership of the Association increased to 856. Members addressed, and the Auxiliary prepared and mailed, more than 90,000 letters before the primaries and general elections. Advertisements were placed in each of the local daily papers explaining the A.C.M.A. unconditional guarantee of needed medical care for everyone, and the first skirmish of the 1947 battle against compulsory health insurance resulted from our inability to find a single person in Alameda County—the Governor's home county—who needed medical care the patient couldn't get because he couldn't pay a doctor.

Credit for our accomplishments and rapid progress of our Association toward its ultimate goal, of which the above presents only highlights, goes to no single individual, but rather to the team play of nearly all of our members, our officers, our committees, and a hard-working A.C.M.A. Headquarters Staff, which has grown to 17 full-time lay employees. It is significant that nowhere in America will be found better feeling and closer cooperation between physicians than has been observed in Alameda County during the past year.

It is my sincere belief that the A.C.M.A. report for next year can start with the statement: "Alameda County now has in full and successful operation what its officers and members believe to be a model county medical society public relations program."

DOROTHY M. ALLEN, *Secretary.*

Contra Costa County Medical Society

The year 1946 has been an unusually active one for the Contra Costa County Medical Society. Of major interest was the participation in the fight against socialized medicine. In addition to the activities common to all county medical societies, Contra Costa County joined with six other Bay Area counties in forming a coordinating group, whose responsibility it is to unify the efforts of the various counties in combating socialized medicine, and to help to establish a uniform front in public relations.

Contra Costa County wishes to pay a special tribute to Rollen Waterson, Lay Secretary of Alameda County, for his help in developing improved collection methods and in obtaining lower rates in health and accident and malpractice insurance.

County Society dues were raised from $5 to $10.

Our changes in membership included two departures and twelve new members, a net gain of ten members.

H. O. NEUFELD, *Secretary.*

EIGHTH DISTRICT

Alpine, Amador, Butte, Colusa, Eldorado, Glenn, Lassen, Modoc, Nevada, Placer, Plumas, Sacramento, Shasta, Sierra, Sutter, Tehama, Yolo, and Yuba Counties.

Frank A. MacDonald, *Councilor.*

Butte-Glenn Medical Society

The Butte-Glenn Medical Society continued to function during the war years as usual. In the Chico area, which normally had about 27 members, the number dwindled to 12. Since the cessation of hostilities our membership is now back to its original 27. Our total membership is well over 40.

During the past year we have held our regular monthly meetings; some addressed by those who had been overseas and by speakers from Sacramento and San Francisco. Our meetings, which are very well attended, are preceded by a dinner, at which the wives of the members are in attendance, after which the Women's Auxiliary holds separate meetings.

All committees of the Society are doing their part and the situation in the Society and among the members in general is all that one can deserve.

J. O. CHIAPELLA, *Secretary.*

Tehama County Medical Society

The Tehama County Medical Society at its regular meeting the evening of January 15, 1947, elected the following officers for the year 1947: J. L. Faulkner, M.D., President; O. T. Wood, M.D., Vice-President; A. H. Meuser, M.D., Secretary and Treasurer. Doctor O. T. Wood was elected delegate and Doctor E. R. Wilson, alternate. Doctor Roderick Thompson has returned from service in the Navy and has resumed active practice.

A. H. MEUSER, *Secretary.*

Yuba-Sutter-Colusa Counties Medical Society

The Yuba-Sutter-Colusa County Medical Society performed its functions in streamlined fashion throughout 1946. Unity and oneness of purpose were outstanding throughout the year. The smoothness with which the various committee chairmen conducted the affairs was most gratifying to the officers. The entire program of the Society was so conducted that no special meetings had to be called at any time. Eight regular monthly meetings were held, meetings being suspended June to September inclusive.

Each meeting program was streamlined to omit all unnecessary business, in order to devote as much time as possible to the scientific side of medicine and surgery. Dr. John W. Linstrum served as program chairman, and is to be complimented upon the fine selection of speakers that appeared before the Society.

Dr. Frank B. Reardan of Sacramento spoke on "Some Aspects of Heart Failure." Dr. C. A. Scherer, Public Health officer, conducted a symposium on Public Health Problems. Dr. Adolph Ogaard gave a paper on "Dissecting Aneurysma," illustrating his lecture with lantern slides. Doctor Frank Lee discussed "Advances in Psychosomatic Medicine." Doctor John Lawson, spoke on "Radium and X-ray Therapy of Superficial Lesions." Doctor A. M. Blumenfeld gave a most interesting and instructive illustrated talk on "Tumors of the Breast."

The guest speaker for the final meeting of the year, was the Councilor for the Eighth District, Dr. Frank McDonald. He presented the political side of medical practice, informing the Society what has been taking place in both state and federal legislative houses.

During the year an attempt, by private hospital management, was made to have the Society form a hospital staff. This has not been consummated. Note is made that hospital beds have been at a premium throughout the year.

A clipping bureau was instituted to accumulate articles of general medical interest. The files are available to all physicians. The subjects are cross indexed.

There has been a spirit of fine cooperation between the Society and the local Red Cross, and Tuberculosis Associations.

The members of the Camp Fire Girls, Boy Scouts, and Y.M.C.A. were given free physical examinations preceding their attending summer camps.

During the month of October the Public Relations Committee, headed by Dr. Stanley Parkinson, did a nice piece of work in the political campaign, first polling each candidate concerned as to his policies and attitude toward socialized medicine, and followed through to see practically all candidates which the Medical Society sponsored elected to office.

During the year the fee schedule of the Society was raised approximately 33⅓ per cent of minimum fees, and a new fee schedule booklet was printed for distribution to the membership.

During November a large one-day advertisement was displayed in each of the three local newspapers, welcoming back to private practice the returning veteran physicians: Colonel Gransville Delamere, Colonel Anthony M. Fratis, Lt. Col. Robert L. Hamilton, Lt. Col. Charles B. Kimmel, Lt. Commander Neal M. Loomis, Captain Benjamin Miller, Major Stanley R. Parkinson, Captain Phillip Thunen, Major Leon M. Swift.

During the year the following physicians were elected to Society membership: C. A. Scherer, Harold Simons, Walter Schmidt, Paul C. Cress. Robert Hodgins was elected to membership by certificate of transfer from San Bernardino County. Dr. Lorrin Denny on transfer from San Diego County.

The highlight of the year was the annual banquet, which has been held for many years at the time of the November meeting, at the Riverside Hotel in Colusa. Almost the entire membership was in attendance.

After considerable planning and communicating with various General Practitioners' sections, following the American Medical Association meeting in San Francisco in July, a General Practitioners' Section of the County Medical Society was authorized and organized in October, 1946. The chairman of the section is Dr. Stanley R. Parkinson and the Secretary is Dr. Anthony Fratis. The meetings of the section are held the first Wednesday of each month, and it is the policy of the section to have papers presented by its members for mutual benefit and to guard the sanctity of the right to be general practitioners.

The newly elected officers for 1947 are: President, John W. Scott, M.D., Colusa; Vice-President, Ermorine Edwards, M.D., Marysville; Secretary-Treasurer, Leon M. Swift, M.D., Marysville.

It is the consensus of opinion that we have completed a most successful year of Society work in spite of numerous handicaps.

LEON M. SWIFT, *Secretary.*

Sacramento Society for Medical Improvement

The Sacramento Society for Medical Improvement meets at 8:30 p.m. on the third Tuesday of each month in the auditorium of the Nurses' Home at Mercy Hospital, 40th and Jay Streets. No meetings are held during the vacation months of July and August. Programs are arranged by a committee, and the December meeting is devoted to Society business and the election of officers for the ensuing year. No bulletin is published by the Society, but the programs of the meetings are announced on printed notices which are sent to all local physicians and other interested physicians in nearby communities. Notices of the monthly meetings are also sent to physicians in military service at the adjacent army posts. The following speakers and programs were presented during the year:

January 15—Dr. Chester Cooley, Mr. William Bowman and Mr. Clem Whittaker discussed California Physicians' Service.

February 19—Symposium on War Medicine and Surgery by members of the 51st Evacuation Hospital.

March 15—Annual Banquet.

April 16—Conclusion of Symposium on War Medicine and Surgery.

May 21—Symposium on urological diseases by Drs. Curtis McDonnell, Max Isoard, Edward Beach, Carl Burkland, Hugh Simmons and Nathan Hale.

June 18—Discussion of State Vocational Rehabilitation Program by Mr. H. D. Hicker.

September 17—Dr. Harold Downing of Fresno discussed "Operative Treatment of Recurrent Dislocation of the Shoulder."

October 15—Dr. Stone and Dr. B. V. A. Low-Beer discussed "The Use of Radioactive Isotopes in Medicine."

November 19—Mr. Rollen Waterson, Executive Secretary of Alameda County Medical Society, talked on the workings of his organization. Dr. David Wood of Stanford University discussed the work of Cancer Clinics. Mr. John Hunton, Mr. Clem Whittaker, Dr. Dwight Murray and Dr. John Cline discussed the Voluntary Health Insurance Program.

December 17—Annual Business Meeting.

The Society has a membership of 187, as of January 1, 1947. There are in addition four retired members and one honorary member.

Drs. Henry L. Saverien and E. C. Turner died during 1946.

EDMUND E. SIMPSON, *Secretary.*

Shasta-Trinity County Medical Society

The Shasta-Trinity County Medical Society has an active membership of 20. During the year 1946 two members were released from the armed services and have returned to the practice of medicine in the county.

The Shasta-Trinity County Medical Society meets regularly on the second Monday of each month, except during the summer months of June, July and August.

JULIUS M. KEHOE, *Secretary.*

Yolo County Medical Society

The Yolo County Medical Society has been able to obtain excellent speakers during the past year. Dr. Arthur Grollman of Southwestern Medical College addressed the Society at our December meeting. His lecture on Carbohydrate Metabolism was most educational.

We continue to have an acute nursing shortage which has caused many hospital beds to be vacant. The Board of Supervisors has deemed it necessary to open the County Hospital to private patients until sufficient bed space can be provided elsewhere. The Society is actively interested in the Cancer Program and has approved of the formation of a Tumor Center at the Woodland Clinic. This center will begin operation after official approval by the proper state authorities.

EMERY LEIVERS, *Secretary.*

Placer-Nevada-Sierra Counties Medical Society

The Placer-Nevada-Sierra County Medical Society held no formal meetings during the year.

The membership of the Society is now 30 paying members and one life member.

VERNON W. PADGETT, *Secretary.*

NINTH DISTRICT

Del Norte, Humboldt, Lake, Marin, Mendocino, Napa, Siskiyou, Solano, Somona, and Trinity Counties.
John W. Green, Vallejo, *Councilor.*

Humboldt County Medical Society

Under the able leadership of Walter Dolfini, M.D., the Humboldt County Medical Society had a very successful year in 1946.

The year saw the return to private practice of all the men from the armed forces. We welcomed ten new members into the Society.

In 1946 a full-time county health officer was obtained and the organization of the Public Health Department for the county is under way.

WAYNE P. MCKEE, *Secretary.*

Marin County Medical Society

The Marin County Medical Society had a very successful year during 1946. The membership has increased to 61 members. Two members left the county and five new members were accepted by transfers from other societies. Four doctors have become members by application on credentials. Two of our members have not returned from military service as yet. One is known to be out of the service and in school; the other has not reported.

Ten professional meetings have been held during the year and all meetings have been well attended. Good fellowship continues to exist among all the members.

All the doctors in the county appear to be busy in general medicine and surgery, also the specialties. The nursing situation still remains unsatisfactory, but will gradually improve. The hospital situation is even worse than during wartime. The two hospitals in this county are inadequate to take care of the bed situation. A new hospital to be built by a bond issue is contemplated and the committee appointed is busy working out fundamental details. The obstetrical situation still is well in hand, although many of the mothers go home on the fourth or fifth day, none being delivered in the homes.

CARL W. CLARK, *Secretary.*

Solano County Medical Society

A review of the activities of this Society for 1946 follows:

On January 8, 1946, a business meeting was held with discussion of problems concerning prepaid medical plans and disciplinary action by the Society concerning the unethical conduct of one of the members. Standing committees were announced by the president, and plans for a two-day surgical symposium circulated.

In February the second meeting of the year was held to discuss prepaid medical care programs, veterans' care program and the progress of the California Physicians' Service commercial plan in Vallejo.

The March 12, 1946, meeting was a scientific program by Dr. John Miller of Stanford University and Dr. E. Shaw of Childrens and University of California Hospital. The usual business meeting convened.

A dinner meeting was held in March, 1946, at the Ryder Street Cafeteria. A scientific program by Dr. S. Sherrick, Dr. Carl Mauser and Dr. Leon Woods on the subject of obstetrical difficulties.

The April 16, 1946, meeting consisted of a business meeting, in which the subject of the A.M.A. convention was discussed.

On May 14, 1946, Dr. Madeley made a report of the recent C.M.A. meeting before the House of Delegates. A plan for employing an executive secretary for four counties, Marin, Napa, Sonoma and Solano was discussed.

On June 16, 1946, the forthcoming tri-county medical meeting was discussed at a special meeting.

On July 25, 1946, a meeting was held to discuss the fate of the Vallejo Community Hospital, of which financial support will be entirely in the hands of the local community, as federal funds would no longer be available after January 1.

On August 27, 1946, a meeting was held and the principle business was discussion of the Bureau of Medicine Economics by Mr. Roland Waterson, executive secretary of the Alameda County Medical Society.

At the September meeting, Dr. Larsen, Medical Director of C.P.S., outlined the status of the C.P.S.-Veterans' Administration program.

At the November, 1946, meeting officers were elected for the coming year: H. Randall Madeley, M.D., President; Felix Rossi, M.D., Vice-President; Charles H. Widenmann, M.D., Secretary and Treasurer, and Dr. H. Randall Madeley, delegate to C.M.A. New business was consideration of Physicians' Exchange plans for participation by doctors in ownership and management of the Vallejo General Hospital.

A special meeting was held December 14, 1946, for discussion of the hospital situation in Vallejo.

CHARLES H. WIDENMANN, *Secretary.*

Mendocino-Lake Counties Medical Society

At the annual meeting of the Mendocino-Lake Counties Medical Society for the purpose of election of officers and reports of the various committees, J. E. Gardner was re-elected president and E. C. Bennett, Secretary-Treasurer. L. K. VanAllen was again chosen as delegate to the state convention and Walter Rapaport elected his alternate.

Our Society consists of 26 members, of whom 11 served in the military or armed forces. Most of the others served in the Selective Service. We take pardonable pride in their promotions and citations. One of our members, Walter Rapaport, received the Medal of Commendation.

E. C. BENNETT, *Secretary.*

Sonoma County Medical Society

The total membership of the Sonoma County Medical Society at present is 67, with one member still in the armed service. Fourteen members were lost to the Society during 1946, as follows: Death of M. F. Clark, M.D., one member retired, six transferred to other Societies, and six resigning from membership. Six new members were added during the year. Seventeen of our members were serving in the armed forces during 1946.

Ten meetings were held. The June meeting was held at the Sonoma State Home, the Society being dinner guests of Dr. F. O. Butler, following golf in the afternoon.

The September meeting was a joint meeting of the Sonoma County Medical Society and the Ladies' Auxiliary, 93 persons attending. Ten new physicians and their wives who have come to Sonoma County during the past 12 months were introduced at this time. The program consisted of the following: An interesting report of the customs and practice of medicine in Alaska, by Noble Dick, M.D., who has spent several years in that region; Dr. J. Hubert Sturges showed interesting color films of medical work and other things of interest in South Africa, where he had previously practiced.

Dr. Frank P. Swire, was lost to us in a fatal airplane accident on Christmas Day.

RAIMOND F. CLARY, *Secretary.*